NONPROFIT HOSPITALS' APPROACH TO COMMUNITY HEALTH NEEDS ASSESSMENT: A MIXED METHODS STUDY

A Dissertation

by

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ABSTRACT

Nonprofit hospitals are tax exempt but must demonstrate community benefit to the Internal Revenue Service (IRS) to maintain this status. In attempts to improve accountability, the Patient Protection and Affordable Care Act of 2010 includes a provision requiring all nonprofit hospitals to conduct a community health needs assessment (CHNA) and implement strategies to address identified priorities. The purpose of this mixed methods study was to gain a better understanding of how nonprofit hospitals are fulfilling this relatively new IRS requirement. The first paper presents findings based on the review, evaluation, and scoring of ninety-five CHNA/implementation strategies reports completed by Texas nonprofit hospitals. Reports were evaluated and scored on specific evaluation criteria using a public health framework to derive an overall report quality score. The second paper presents findings related to community participation in assessment and planning processes using report evaluations and interviews with key informants and community stakeholders. Paper three examines interpretations and the implementation of the IRS regulations, currently in draft form, by nonprofit hospitals in Texas, also using data obtained through report evaluations and interviews. Results indicated considerable variation in the assessment and planning approaches, community participation, and interpretation and implementation of the draft regulations. Recommendations are made to provide guidance to nonprofit hospitals and to inform the final IRS regulations, specifically requiring the use of a public health assessment and planning framework to conduct the CHNAs.

DEDICATION

To my mom, S. Deneise Pennel, in memoriam

Thank you for giving me the heart for public health

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

Introduction

Nonprofit hospitals, like other nonprofit organizations, are tax exempt. Nonetheless, they must demonstrate to the Internal Revenue Service (IRS) that they provide benefit to the community in which they are located to maintain this status. In attempts to improve accountability, the Patient Protection and Affordable Care Act of 2010 (ACA) includes a provision requiring all nonprofit hospitals to conduct a community health needs assessment (CHNA) and develop an implementation plan. The IRS, the bureau responsible for the regulation and enforcement of Section 9007 of the ACA, has yet to develop and issue finalized regulations. However, draft regulations provided general guidance to nonprofit hospitals for the first three-year cycle of the assessment and planning processes and report development (IRS, 2013, April 5). Very little research has been conducted on nonprofit hospitals' approach to this requirement, perhaps because of its relative newness.

When discussing the draft IRS regulations, we will refer to the assessment process and report as *community health needs assessments (CHNA)*, as that is how it is identified in the regulation. However, there are issues and potentially negative consequences to perceiving these processes as "needs" assessments. According to Kettner, Moroney, and Martin "needs assessment is conceptually ambiguous." (1999, p. 45). Not only are there different theoretical understandings and definitions of need, there

are different types of need and methods for collecting need data and identifying need. Perspectives on need will differ based on social, cultural, political, economic, ethnic, gender, and other factors. Finally, need is informed by expectations, which change over time (Kettner, Moroney, & Martin, 1999). A focus on need can lead to other problems, including community members identifying as powerless victims, fragmentation of efforts to provide solutions to problems, and blame toward community leaders, which leads to further community division (Kretzman & McKnight, 1993). Finally, a need-based model, as opposed to an asset-based approach, directs funding to service providers instead of residents and can lead to dependence on outside help, often providing false hope that problems can be fixed (Kretzman & McKnight, 1993). Due to these issues, when not referring to the IRS regulation, we will refer to the assessment process as *community health assessment (CHA)*. This literature review that follows will provide an overview of community health assessments followed by a discussion of the nonprofit hospitals, community benefits, and the requirements of the draft regulations.

Community Health Assessment

Assessment is one of public health's three core functions (Committee for the Study of the Future of Public Health, 1988). As a core function, assessment activities include monitoring health status to identify community health problems, diagnosing and investigating community health problems and hazards, and evaluating the effectiveness, accessibility, and quality of public health services (Centers for Disease Control and Prevention [CDC], 2013, July 3). Community health assessment (CHA) is an important

aspect of the assessment function and informs the development, implementation, and evaluation of effective health improvement programs and policies.

Definitions of community health assessment. There are varying definitions of and, thus, approaches to community health assessment (CHA). The National Association of County and City Health Officials defines CHA as "a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community" (National Association of County & City Health Officials [NACCHO], n.d). With a similar definition, the Institute of Medicine describes community health assessment as a process of systematically collecting, assembling, analyzing, and making health status statistics, community health needs, and epidemiologic and other studies available (Committee for the Study of the Future of Public Health, 1988). The Public Health Accreditation Board defines community health assessment as "a process of collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health" (Public Health Accreditation Board [PHAB], 2010).

While a variety of CHA methods, tools and processes may be used, "the essential ingredients are community engagement and collaborative participation" (Turnock, 2001, p. 325). This view of CHA is reflected by Marti-Costa and Serrano-Garcia, who argue that community needs assessment is not a neutral or objective process with value-free, apolitical, and ahistorical characteristics, but is an ideological, "political process that can be conceptualized as a tool for the organization, mobilization and consciousness-raising of groups and communities" (1983, p.77). Thus, there is fairly wide agreement that in

addition to producing health status data, CHA is also a process to engage and mobilize community members.

Purpose of community health assessment. According to Hancock and Minkler, health status indicators, such as mortality rates, are important in CHAs, but "this needs to be balanced by information on people's perceived state of health, their social and physical living condition, and their behaviors" (1999, p.141). CHAs can identify and aid understanding of local differences and health disparities as well as direct limited resources to areas or populations in greatest need. They are important, not only to identify community health issues, but also to identify available local assets and resources (Kretzman & McKnight, 1993). Finally, CHAs are "an important organizing and facilitation tool that increases citizen participation and population education" (Felix, Burdine, Wendel, & Alaniz, 2010, p. 12). Community participation can lead to more accurate identification of local health issues and assets, as well as build community capacity to further build local assets and address issues.

According to Marti-Costa and Serrano-Garcia, a more subjective purpose of a community assessment is to:

- Measures, describe, and understand community lifestyles
- Assess community resources to lessen external dependency
- Return needs assessment data to facilitate residents' decision-making
- Provide skill, training, leadership, and organizational skills
- Enable consciousness-raising

(Marti-Costa and Serrano-Garcia, 1983, p. 79)

The CHA process is not just about identifying health problems, but prioritizing these issues; identifying available resources, resource gaps, and strategies to address problems; engaging community members for collaborative action planning; and through engagement, build community capacity.

Community health assessment models. Previously, public health agencies, often in collaboration with other community partners, have largely led CHA efforts. There are various CHA models to conduct community health assessment and planning processes, including Planned Approach to Community Health (PATCH), Mobilizing For Action Through Planning And Partnerships (MAPP), Community Health Improvement Process (CHIP), and the community health development model (Burdine, Felix, & Wendel M, 2007; Burdine, McLeroy, Blakely, Wendel & Felix, 2010; Felix, Burdine, Wendel, & Alaniz, 2010; Institute of Medicine [IOM], 1997; National Association of County and City Health Officials [NACCHO], 2013; U.S. Department of Health and Human Services, n.d.). CHA models, using a public health framework, essentially include the same general components: gathering and analyzing quantitative and qualitative data; using data to identify health issues; using broad social determinants of health to identify influences on health issues, including environment, behavior, socioeconomics, and culture; identifying resources and resource gaps; identifying health disparities; engaging and mobilizing the community; organizing and sharing findings; setting health priorities; developing an action plan to address health priorities; implementing action plans; and providing opportunities for continual feedback with community members (Centers for Disease Control and Prevention [CDC], 1999; CDC,

July 3, 2013; Centers for Disease Control and Prevention [CDC], October 25, 2013; Centers for Disease Control and Prevention [CDC], March 21, 2013; Centers for Disease Control and Prevention [CDC], 2011; Felix, Burdine, Wendel, & Alaniz, 2010; IOM, 1997; Kretzman & McKnight, 1993; Myers & Stoto, 2006; NACCHO, n.d; NACCHO, 2013; Turnock, 2001; University of Kansas Work Group for Community Health and Development, 2013).

Nonprofit Hospitals and Community Benefit

In 1956, the IRS determined a hospital could qualify as a tax-exempt charitable organization and issued Revenue Ruling 56-185 (Hanson, 2005; Internal Revenue Service [IRS], 1956; Joint Committee on Taxation, 2006, September 12). Under this ruling, nonprofit hospitals were required to provide charity care for the poor, based on their financial ability to do so, in exchange for nonprofit status. With the advent of Medicaid and Medicare, employer supplied health insurance, and third party payers, nonprofit hospitals were not providing the same level of charity care they had in the past (Joint Committee on Taxation, 2006, September 12). In 1969, the Internal Revenue Service (IRS) established Revenue Ruling 69-545, the community benefit standard for nonprofit hospitals (Internal Revenue Service [IRS], 1969). To maintain the nonprofit status hospitals must:

1. operate a full-time emergency room (ER) open to all patients, regardless of ability to pay, with some exceptions;
2. accept patients able to pay for care, either directly or through third party reimbursement;

3. be governed by a board of independent community members;
4. make medical staff privileges available to all qualified physicians in the area; and
5. use excess funds to improve the quality of patient care, expand facilities, and advance training, education, and research programs.

(Congressional Research Services, 2009, November 10)

The 1969 revenue ruling allowed a broader definition of community benefit, as well as hospital interpretation to its meaning, than the previous ruling. However, this lack of definition led to ambiguity (Bazzoli, Clement, & Hsieh, 2010). It wasn't until 2007, with the development of the IRS Schedule H reporting form, that the IRS created community benefit categories. These categories were charity care, unreimbursed costs for means-tested government programs (e.g., Medicaid shortfalls), subsidized health services, community health improvement services and community-benefit operations, research, health-professions education, and financial and in-kind contributions to community groups (Bazzoli, Clement, & Hsieh, 2010; Lunder & Liu, 2008).

Over the past twenty years, there have been concern as to whether non-profit hospitals are meeting minimum community benefit standards in return for their tax-exempt status. In 2006, the Congressional Budget Office estimated the overall value of federal, state, and local tax exemptions for nonprofit hospitals was $12.6 billion (Congressional Budget Office, 2006). However, studies suggest there is little difference between community benefit provided by nonprofit and for-profit hospitals and the community benefit nonprofit hospitals provide is much less than the tax exemption benefits the hospitals receive (Congressional Budget Office, 2006; Government

Accountability Office [GAO], 2005; Government Accountability Office [GAO], 2008; Nicholson, Pauly, Burns, Baumritter, & Asch, 2000).

Another concern is the type of community benefit nonprofit hospitals provide. A recent study examined the benefit nonprofit hospitals provided to communities in the United States (Young, Chou, Alexander, Lee, & Raver, 2013). While contributions varied, overall the study found nonprofit hospitals applied 7.5 percent of their operating expenses to community benefit. Of this 7.5 percent, 1.9 percent went to charity care, 3.4 percent went to unreimbursed costs for means-tested government programs, 1.1 percent to subsidized health services, 0.4 percent to community health improvement, 0.2 percent for cash or in-kind contributions to community groups, 0.1 percent for research, and 0.4 percent for health-professions education (Young, Chou, Alexander, Lee, & Raver, 2013). Over eighty-five percent of community benefit expenditures were devoted to patient care services. Of this more than forty-five percent were used to offset unreimbursed costs for means-tested government programs, primarily Medicaid losses. Only five percent were devoted to community health improvement activities (Young, Chou, Alexander, Lee, & Raver, 2013).

Community Health Needs Assessment and Implementation Strategies Legislation

The particular ACA legislation of interest, TITLE IX—REVENUE PROVISIONS, Subtitle A—Revenue Offset Provisions, Sec. 9007, Additional requirements for charitable hospitals, was enacted March 23, 2010 (IRS, 2013, April 5). The IRS developed draft regulations for the first three-year assessment cycle, but finalized regulations have not been developed or issued. The draft regulations require

that nonprofit hospitals identify and prioritize community health needs; inventory resources; develop an implementation strategies report to address health needs; and involve stakeholders with public health knowledge and expertise and leaders, representatives, or members of medically underserved, low-income, and minority populations in the community (IRS, 2013, April 5).

Elements of Community Health Needs Assessment and Implementation Strategies

Community health needs assessment. To meet this requirement, nonprofit hospitals must conduct an assessment and develop a CHNA report. In this report, hospitals must define the community they serve and describe how that was determined. Hospitals must describe the data used to identify community health needs, any other information sources used in the assessment, and data collection and analysis methods. The report must identify significant community health needs and provide a prioritized description of the significant health needs. Finally, the report must describe the process and criteria used to identify and prioritize health needs and potential measures and resources to address significant health needs (IRS, 2013, April 5).

Implementation strategy. In addition to the CHNA report, nonprofit hospitals must develop and adopt one or more implementation strategies to address the health priorities identified through the CHNA. The report must include how hospitals plan to address significant health needs, the anticipated impact of the actions, plans to evaluate impact, identification of programs and resources the hospital plans to commit to address the health needs, and a description of any planned collaborations to address health needs between the hospital and other organizations. If there is an health priority identified the

hospital will not address, the report must explain why they do not intend to address it (IRS, 2013, April 5).

Partner involvement. Throughout the assessment and planning process, the IRS requires nonprofit hospitals include stakeholders and take into account input from agencies, organizations, and/or individuals who represent the broad interests of the community. Specifically, those with public health knowledge and expertise and leaders, representatives, or members of medically underserved, low-income, and minority populations in the community must be involved in the process. The reports must generally summarize the nature and extent of stakeholder input, how this information was provided, the time period for which the input was provided, the names of the organizations providing input, as well as a description of the medically underserved, low-income, or minority populations being represented. Other collaborators or contractors must also be identified. The hospital must make the report publicly available by posting it on the hospital's website or website of another collaborating organization. There must also be an opportunity for public review and comment by members of the community (IRS, 2013, April 5).

This new requirement has potential to improve disease prevention and health promotion activities as well as community health outcomes. Further, with the legislation tied to the IRS, there may be greater compliance due to the financial consequences of noncompliance. However, as the author and enforcer of this regulation, the IRS has little experience in community health. Further, the intent and purpose of the original legislation and draft regulations are unclear. Very little information exists as to how

nonprofit hospitals will interpret and implement this requirement, the extent of the input contributed by community stakeholders, and focus on broader social determinants of health, all of which increase the likelihood of improving population health.

Questions about Hospitals' Approach to Community Health Needs Assessment

Public health versus medical paradigm. Due to often-divergent viewpoints between medical and public health disciplines, it is not known how nonprofit hospitals will approach components of the draft regulations and to what extent assessment and planning processes will represent a public health framework. Professional training and the way in which community and health are perceived often differ significantly between medical and public health disciplines. Public health employs a broad conceptualization of health that includes biology and genetics, individual behavior, social environment, physical environment, and health services (CDC, 2013, March 21). The medical model emphasizes diagnosis, treatment, and care of the patient, while the public health model stresses prevention and health promotion for the population.

The emphasis of U.S. policy and funding on sick care, medical treatment, and medical technology ahead of population health, health promotion, and disease prevention has influenced the development of the U.S. health system and led to poorer health outcomes when compared to other developed countries. In fact, investment in health care contributes to rising health care costs, which could replace funding from other areas that have a greater influence on population health, such as education, job creation, housing, and the environment (Magnan, Fisher, Kindig, Isham, Wood, Eustis, Backstrom, & Leitz, 2012). The United States spends significantly more per capita and

percent gross domestic product on health care than any other country, yet health outcomes are considerably worse than most developed nations (Squires, 2012). Health disparities in the U.S. population contribute to lower life expectancy and increased morbidity and mortality rates.

Historically, it has been argued that health and illness are largely influenced by social and economic factors (Doyal, 1979; McKeown, 1976). While medical care receives much of the credit for modern improvements in health, much of the historical decline in mortality from the 19th to the 21st century primarily resulted from public health improvements in the environment, hygiene, nutrition, and standards of living (McKinley and McKinley, 1986). Medical interventions were not as likely as public health approaches to reduce the toll from principal causes of death in the past (i.e., infectious disease) and they are unlikely to do the same for the top causes of death of today (i.e., chronic disease). This reductionist view places the responsibility of health on individuals and physicians rather than considering broader causes of health issues.

Broader determinants of health. According to Healthy People 2020, the five key determinants of health are economic stability, education, social and community context, health and health care, and neighborhood and built environment (U.S. Department of Health and Human Services, 2014, May 24). The public health paradigm includes medical care, but also focuses on the broader social determinants of health, including environmental, behavioral, socioeconomic, and cultural factors (CDC, 2013, March 21; Magnan, Fisher Kindig, Isham, Wood, Eustis, Backstrom, & Leitz, 2012). Research strongly suggests clinical measures, such as quality of and access to health

care, contribute little to overall health compared to other factors. Magnan et al.'s model, adapted from the University of Wisconsin Population Health Institute, estimates that health care services (e.g., access to care, quality of care) account for about 20 percent of the variation in community health status. The remaining factors, social and economic factors, health behavior, physical environment, contribute 40 percent, 30 percent, and 10 percent, respectively (Magnan, Fisher Kindig, Isham, Wood, Eustis, Backstrom, & Leitz, 2012).

Communities as systems. Communities cannot be treated as simple, linear, and static, which makes it difficult to identify, assess, and address health issues. Many recommend viewing community as a complex system of dynamic, moving parts that interact nonlinearly to create emergent properties (Hawe, Shiell & Riley, 2009; McLeroy, Bibeau, Steckler & Glanz, 1988; Schensul, 2009; Trickett et al., 2011). Systems-thinking is "necessary to gain a greater understanding of the complex adaptive systems involved in both causing and solving public health problems" (Leischow, Best, Trochim, Clark, Gallagher, Marcus, & Matthews, 2008, p. S198). Using a systems-based approach such as the social ecological framework differs from sole reliance on the medical model to "fix" health problems. This complex community system requires that assessments and intervention planning consider the broader determinants of health and community context (Trickett, 2009).

Social ecological model. The social ecological model is a nested model in which determinants of health are found within various levels and the constant interactions between these levels: intrapersonal, interpersonal, organizational, community, and policy

(McLeroy, Bibeau, Steckler & Glanz, 1988). Further, the relationship between individuals and their "social context is complex and is shaped and constituted by social, cultural, economic, political, legal, historical, and structural forces" (Burke, Joseph, Pasick, & Barker, 2009, 61S). Research strongly suggests the broader system and environment contributes to health and social problems and, thus, must be part of the solution. Concerns about nonprofit hospitals' approach to the health assessment and planning processes and reports largely arise from clinical leanings in identifying health needs and strategies to address these needs.

Dissertation Overview

The following chapters of this dissertation will provide insight into nonprofit hospitals' approach to the health assessment and planning draft regulations using a two-phase, mixed methods case study methodology. Phase I informed the research questions:

1) To what extent did the CHNA/implementation strategies reports reflect a public health framework?
2) What characteristics facilitated the health assessment and planning processes?
3) To what extent did the health assessment and planning process have potential to mobilize the community?
4) How were draft regulations interpreted and implemented by nonprofit hospitals?

Research questions one and two are primarily addressed in Chapter II. Research question three is primarily addressed in Chapter III. Research question four is primarily addressed in Chapter IV. Phase I also informed the selection of the six case studies used in phase II.

Chapter II presents the findings of phase I, which entailed the review, evaluation, and scoring of ninety-five CHNA/implementation strategies reports completed by Texas nonprofit hospitals. Reports were evaluated and scored on specific evaluation criteria using a public health framework to derive a report quality score. Hospital-related and other report characteristics were analyzed to understand relationships with report quality. Chapter III presents phase I and phase II findings related to community participation in health assessment and planning processes and the draft regulation's potential to mobilize communities. First, phase I quantitative findings are presented related to the extent of community participation for the ninety-five CHNA/implementations strategies reports. Next, phase II findings are presented related to community participation; these qualitative findings are based on key informant, consultant, and community stakeholder interviews for the six case study sites. Chapter IV examines interpretations and the implementation of the draft regulations by nonprofit hospitals in Texas. Using phase I and phase II findings, it provides recommendations intended to provide guidance to nonprofit hospitals as well as to inform the finalized IRS regulations.

CHAPTER II

NONPROFIT HOSPITALS' APPROACH TO COMMUNITY HEALTH NEEDS ASSESSMENT

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) includes a provision requiring all nonprofit hospitals to conduct a community health needs assessment (CHNA) and develop an implementation strategies plan. The CHNA requirement requires nonprofit hospitals conduct a community health needs assessment (CHNA) at least every three years and implement strategies to address identified priority needs (IRS, 2013, April 5). The Internal Revenue Service (IRS), the bureau responsible for the regulation and enforcement of Section 9007 of the ACA, provides general guidelines to nonprofit hospitals regarding the CHNA requirement (IRS, 2013, April 5). Included in this requirement are identifying and prioritizing community health needs; inventorying resources; developing an implementation strategies report to address health needs; and involving stakeholders with public health knowledge and expertise and leaders, representatives, or members of medically underserved, low-income, and minority populations in the community (IRS, 2013, April 5). Nonprofit hospitals, like other nonprofit organizations, are tax exempt, but must demonstrate community benefit to the IRS to maintain this status. Very little research has been conducted on nonprofit hospitals' approach to the CHNA requirement, perhaps because of its relative newness. Using CHNA/implementation strategies reports developed by nonprofit hospitals in

Texas, we will evaluate and analyze various CHNA methods, report components, and influential factors. In addition, we will assess CHNA/implementation strategies report quality using a public health framework.

Community Health Assessment

Assessment is one of public health's three core functions (Committee for the Study of the Future of Public Health, 1988). Community Health Assessment (CHA) is an important aspect of the assessment function and is critical in the development, implementation, and evaluation of effective health improvement programs and policies. There are varying definitions of and approaches to CHA. CHA processes, using a public health framework, generally include the following: gathering and analyzing quantitative and qualitative data; using data to identify health issues; using broad social determinants of health to identify influences on health issues, including environment, behavior, socioeconomics, and culture; identifying resources and resource gaps; identifying health disparities; engaging and mobilizing the community; organizing and sharing findings; setting health priorities; developing an action plan to address health priorities; implementing action plans; and providing opportunities for continual feedback with community members (CDC, 1999; CDC, 2011;CDC, March 21, 2013; CDC, July 3, 2013; CDC, October 25, 2013; Felix, Burdine, Wendel, & Alaniz, 2010; IOM, 1997; Kretzman & McKnight, 1993; Myers & Stoto, 2006; NACCHO, n.d; NACCHO, 2013; Turnock, 2001; University of Kansas Work Group for Community Health and Development, 2013).

Due to often-divergent viewpoints between medical and public health disciplines, it is not known how nonprofit hospitals will approach components of the draft requirements and to what extent health assessment and planning processes will represent a public health framework. Professional training and the way in which community and health are perceived often differ significantly between medical and public health disciplines. Public health employs a broad conceptualization of health that includes biology and genetics, individual behavior, social environment, physical environment, and health services (CDC, March 21, 2013). The medical model emphasizes diagnosis, treatment, and care of the patient, while the public health model stresses prevention and health promotion for the population. The medical paradigm places emphasis on medical care, while the public health paradigm includes medical care, but also focuses on the broader social determinants of health, including environmental, behavioral, socioeconomic, and cultural factors (Berg, 2009; Magnan, Fisher, Kindig, Isham, Wood, Eustis, Backstrom, & Leitz, 2012).

Previously, public health agencies, often in collaboration with other community partners and stakeholders, have largely led CHA efforts. The importance of community participation and mobilization in community health assessment and planning processes includes: recognizing the community as a unit of identity; building on strengths and resources; facilitating collaborative partnerships; emphasizing locally relevant problems and an ecological perspective; promoting power-sharing, co-learning and capacity building; improving cultural sensitivity, reliability and validity through quality community participation; increasing community trust and ownership; developing

community systems through a cyclical and interactive process; disseminating the findings and knowledge; and enhancing sustainability (Israel, Schulz, Parker, Becker, 1998; Israel, Schulz, Parker, Becker, Allen, Guzman, 2008; Minkler, 2005).

Nonprofit Hospitals and Community Benefit

The legislation tied to the IRS regulations largely came about due to concerns as to whether nonprofit hospitals are meeting minimum community benefit standards needed to maintain tax-exempt status. Tax-exempt status for nonprofit hospitals translates to billions of tax dollars saved as well as charitable contributions (Congressional Budget Office, 2006; Rosenbaum & Margulies, 2011). However, studies show there is little difference between community benefit provided by nonprofit and for profit hospitals, raising the question of whether nonprofit hospitals merit this continued distinguished status (Congressional Budget Office, 2006; Nicholson, Pauly, Burns, Baumritter & Asch, 2000; Young, Chou, Alexander, Lee, & Raver, 2013). Another concern is the *type* of community benefit nonprofit hospitals provide, with the majority of community benefit expenditures going to direct patient care (Young, Chou, Alexander, Lee, & Raver, 2013).

IRS CHNA and other community benefit requirements may provide opportunities to create linkages between medicine and public health, address disparities, engage the broader community, improve population health, and provide greater benefit to society (Abbott, 2011; Berg, 2009; Magnan, Fisher, Kindig, Isham, Wood, Eustis, Backstrom, & Leitz, 2012; Crossley, 2012). However, there is little evidence this is the approach nonprofit hospitals will take. Hospitals view health through a different lens

than public health and this raises the question as to whether hospitals alone have the necessary training, perspective, and resources to properly assess community health needs and identify appropriate strategies in order to effectively influence population health.

Evaluation Criteria: CHA Processes and Plans

In public health planning, the supposition is that quality plans lead to quality programs, which increase the likelihood of improved health outcomes (Dunet, Butterfoss, Hamre, & Kuester, 2005). Due to the vague IRS guidance, there is a large degree of subjectivity while evaluating the quality of the CHNA/implementation strategies reports. However, criteria exist for the evaluation of quality public health plans, which were gleaned from the literature based on quality characteristics of community health assessments and plans for adolescent pregnancy prevention, obesity prevention, and sustainability planning. These include:

- Partner and stakeholder involvement (Barnett, 2012; Butterfoss & Dunet, 2005; Catholic Health Association [CHA], 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003; Sridharan, Go, Zinzow, Gray, Gutierrez & Barrett, 2007)
- Organizational structure and personnel considerations (Barnett, 2012; CHA, 2013; IRS, 2013, April 5; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003; Sridharan, Go, Zinzow, Gray, Gutierrez & Barrett, 2007)
- Definition of community (Barnett, 2012; CHA, 2013; IRS, 2013, April 5)

- Examination of data (Barnett, 2012; Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Myers & Stoto, 2006; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Identification/prioritization of issues (Barnett, 2012; CHA, 2013; IRS, 2013, April 5; Myers & Stoto, 2006; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Examination of causation (CHA, 2013; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Local contextual considerations (Barnett, 2012; Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Identification of assets/resources (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Clear goals and measurable objectives (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Myers & Stoto, 2006; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Action plan/strategies to address issue(s) (CHA, 2013; IRS, 2013, April 5; Sridharan, Go, Zinzow, Gray, Gutierrez & Barrett, 2007)
- Evidence-based strategies (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)

- Includes multiple ecological levels (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005)
- Description of the process (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Myers & Stoto, 2006)
- Feasibility/sustainability (Barnett, 2012; Butterfoss & Dunet, 2005; Dunet, Butterfoss, Hamre, & Kuester, 2005; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003; Sridharan, Go, Zinzow, Gray, Gutierrez & Barrett, 2007)
- Evaluation of plan (Barnett, 2012; Butterfoss & Dunet, 2005; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)
- Accessibility of plan (Barnett, 2012; Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5; Myers & Stoto, 2006; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003)

These criteria provide a framework for evaluating the quality of CHNA/implementation strategies reports. See Table 2.1 for further description of these criteria.

The IRS regulations have yet to be finalized; however, proposed regulations guided this initial assessment process and CHNA/implementation strategies report components for the first three-year period. Currently, the guidance is broad, open to interpretation, and allows a fair amount of latitude and flexibility. Some adaptability and tailoring is important, as each community and nonprofit hospital is different in terms of resources, demographics, health issues, partners, history, and other contextual factors

Table 2.1.
Community Health Needs Assessment Evaluation Criteria

Source	Partner/stakeholder Involvement	Organizational Structure/Personnel	Define Community
IRS Draft Requirements	Identify organizations/parties with whom the hospital collaborated or contracted assistance in conducting the CHNA; Describe those with public health expertise included; Describe those with medically underserved, low income, and minority populations included; Describe planned collaboration to address health needs between the hospital and other facilities or organizations	Identify resources and programs the hospital plans to commit to address the health needs	Definition of the community served; Description of how that was determined.
Butterfoss and Dunet Dunet et al.	Meaningful stakeholder involvement; Balanced representation (that reflects community)		
Parra-Medina et al.	Developed in collaboration with agencies/organizations in the community	Includes advisory committee or similar structure	
Sridharan et al.	Communication mechanism between stakeholders; Proof of interagency collaboration	Organizational structure to oversee implementation; Identifies staff needs	
Barnett	Shared Ownership of Community Health; Community Engagement; Shared Accountability and Regional Governance	Institutional Oversight	Defining community (jurisdictional issues)
Myers and Stoto			
Catholic Health Association	When possible, conduct assessment in collaboration with other hospitals, local health departments and community partners; Form assessment team/advisory committee that represents community; Seek community input that reflects the racial, ethnic and economic diversity of the community; Validate priorities with community input	Form assessment team/advisory committee that include key staff within the organization	Define community to include primary and secondary service areas and the types of patients the hospital serves (age, gender, conditions treated)

Table 2.1.
Continued

Authors (Year)	Examination of Data (data source, methods)	Identify/Prioritize Issue(s)	Examine Causation of Problem	Considers local context
IRS Draft Requirements	A description of the data and other information used in the assessment; Methods of collecting and analyzing data and information	Identify significant community health needs; Prioritized description of the significant health needs		
Butterfoss and Dunet Dunet et al.	Systematic examination of data; Data are from reliable sources			Match strategies to population; Integration of strategies into existing programs & infrastructure
Parra-Medina et al.	Includes prevalence data	Clearly states the problem	Delineates causation of the problem	Identifies local factors that contribute to the problem; consistent with other local programs
Sridharan et al.	Data-driven planning process			
Barnett	Data Collection and Analysis	Priority Setting		Alignment Opportunities
Myers and Stoto	Clearly identifies data sources (e.g., citations to graphs or tables); Presents data in meaningful subgroups of population (e.g., to assess health disparities)	Includes the most important aspects of the community's health	Clearly indicates the relationships among related health indicators	
Catholic Health Association	Base the assessment on review of public health data collected by government agencies and other authoritative sources; Consider the following types of information: demographics, health indicators, health risk factors, access to healthcare, and social determinants of health; Collect community input using one or more of the following methods: community forums, focus groups, interviews, and/or surveys; Analyze data collected using comparisons with other communities and with federal or state benchmarks and, when available, trends within the community	Identify from three to ten priorities; Align priorities with organizational, state and national priorities; Give priority to persons who are low-income and disadvantaged	Look for disparities and contributing causes of health problems; Understand root causes of needs being addressed	Coordinate hospital and community strategies to ensure the most effective use of resources; Build on existing programs and other community assets when possible

Table 2.1.
Continued

Authors (Year)	Identify Assets/Resources	Clear Goals/Measurable Objectives	Action Plan/Strategies to address issue	Evidence-based	Reflects social determinants of health
IRS Draft Requirements	Description of potential resources to address the significant health needs	Description of potential measures to address the significant health needs	Develop implementation strategy that corresponds to the health needs identified through the CHNA (how issue will be addressed)		
Butterfoss and Dunet Dunet et al.	Assess existing resources	Goals for changing health status; SMART Objectives; Objectives logically related to goals		Strategies based on scientific evidence	Objectives include multiple ecological levels
Parra-Medina et al.	Assesses assets and resources	Clearly defines program objectives; Objectives are written in measurable format; Activities outlined support objectives		Program based on current research	
Sridharan et al.		Revisit goals	Established processes/procedures to ensure agencies fulfill responsibilities		
Barnett					
Myers and Stoto	Provide sufficient focus on positive characteristics (e.g., as well as negative)	Clearly states goals and purpose of CHA			
Catholic Health Association	Use knowledge of community assets in determining priorities	For each prioritized need, identify the goal to be achieved, measurable objectives(s), indicators for determining whether objectives were met, and evaluation measures	Update the implementation strategy upon major changes in community health status and at least every three years	Investigate evidence-based approaches to ensure effective use of hospital and community resources	Identify a range of possible interventions

Table 2.1.
Continued

Authors (Year)	Description of the Process	Feasibility/ Sustainability	Evaluation	Accessibility
IRS Draft Requirements	Description of the assessment process and methods, process and criteria used to identify and prioritize health needs, input provided by partners, and why health priorities not addressed		Plan to evaluate impact	Make report publicly available; Post report on the hospital's website, or website of other collaborating organization
Butterfoss and Dunet Dunet et al.	Documentation of rationale for strategies selected; describe how partners will be involved	Locate, maintain, and sustain resources	Evaluation plan	Understandable; Useful; Designed to elicit interest and support of reader; Wide distribution of plan
Parra-Medina et al.		Realistic; Strategies for seeking funding	Describe how will be evaluated and how findings will be used	Readability
Sridharan et al.		Funding/ sustainability	Continued data collection plan to assess progress toward goals	
Barnett		Strategic Investment and Funding Patterns	Monitoring and Evaluation	Public Reporting: Federal, State, and Local Issues
Myers and Stoto	Sufficiently documents the process and methods used to create the CHA			Uses consistent format; Include a summary and detailed versions; well organized and easy to find content; easy to understand; available online; includes appropriate links; easily photocopied; Includes narrative and graphic representation of key findings; Uses similar structure or data elements as other community planning tools
Catholic Health Association	Document how priorities were identified and who was involved in setting priorities			Distribute report to all partners and contributors; Make the implementation strategy publicly available

that contribute to how community organizations and members work together, make decisions, identify health issues and resources, prioritize health issues, and address health priorities. However, without more specific guidance or evaluation criteria, the requirement's usefulness, applicability, and potential to improve community health outcomes is unknown.

The purpose of this study was to gain a better understanding of how nonprofit hospitals are fulfilling the IRS requirement to conduct health assessments and develop CHNA/implementation strategies reports. Initial steps to improve understanding included (1) creating a mechanism for evaluating CHNA/implementation strategies reports using a public health framework and the IRS guidance; (2) evaluating and scoring a sample of Texas nonprofit hospital reports using this mechanism; (3) providing an initial overview of Texas nonprofit hospitals' reports; and (4) beginning to identify key characteristics and factors that resulted in CHNA/implementation strategies reports of higher quality.

Methods

We conducted a web-based search for Texas nonprofit hospital community health needs assessment and implementation strategies reports, which the IRS requires be made publicly available (IRS, 2011, April 5). Both report sections, the CHNA/implementation strategies, were required to meet study inclusion criteria. Only reports with both sections were included in the evaluation and analysis. We located 135 reports developed by Texas nonprofit hospitals. Forty had not yet included the implementation strategies report section and were excluded from the sample. Thus, we

reviewed, evaluated, and scored ninety-five (n=95) CHNA/implementation strategies reports. This study accounted for approximately fifty-three percent of the nonprofit hospital population in Texas.

We evaluated CHNA/implementation strategies reports using the sixteen criteria items described in Table 2.1 and scored each item using a six-point scale, borrowing from a scale used to assess state plans for obesity prevention (Butterfoss & Dunet, 2005; Dunet, Butterfoss, Hamre, & Kuester, 2005;). Each criteria item that was not addressed was scored zero; items that were low quality or had no detail were scored one; items that were low quality and included very limited detail were scored two; items that were partially or variably addressed were scored three; items that were sufficiently addressed (good, solid job) were scored four; and items that were addressed with high quality and detail were scored five. We reviewed each CHNA/implementation strategies report as a whole and then evaluated and scored each factor independently to the extent possible. There is currently no evidence in the literature that certain factors are more important than others, so we weighted the sixteen factors equally. The cumulative score of these 16 items produced a total report score, which was used as an indicator of CHNA/implementation strategies report quality.

Other characteristics of the CHNA/implementation strategies report collected included the year the CHNA was conducted/published (if these differed, year of publication was used), whether the assessment and report development process was staff- or consultant-led, and whether the hospital collaborated with a local health department to conduct the assessment. These data were obtained from the

CHNA/implementation strategies report. We also gathered characteristics of the hospital and the community in which the hospital was located, including the Rural Urban Continuum Code of the county, hospital size based on the number of hospital beds, whether the hospital was religious/faith-based, whether the hospital was part of a healthcare system or a stand-alone facility, the presence of a city or county health department, and median county income (Texas Department of State Health Services, 2014, March 19; United States Census, 2014, March 27; United States Department of Agriculture, 2013, May 10). Other hospital characteristic data were obtained from CHNA/implementation strategies reports and hospital websites.

Analyses

We generated descriptive statistics, including range, median, and mean for hospital characteristics, report characteristics, the evaluation criteria, and total quality score. We also used Pearson correlation and Spearman rank correlation to determine relationships between variables. Several variables are ordinal, so the results of Spearman are reported. Finally, robust standard errors univariate regression and multiple linear regression forward and backward variable selection method were used to identify hospital, community, and report characteristics that made significant contributions to variability in the CHNA/implementation strategies report quality score as well as built a best-fit model. The forward and backward variable selection method resulted in the same model. Using robust standard errors takes into account the presence of outliers and failure to meet normality and heteroscedasticity assumptions (Chen, Ender, Mitchell, & Wells, 2003). Evaluation criteria were not included in regression analyses, as these were

the basis for the total report score and, thus, there were inherent associations. We used Stata version 12 to conduct all analyses (StataCorp LP, College Station, TX).

Results

Description of Hospitals, Reports, Evaluation Criteria, and Total Scores

Hospital characteristics. Eighty-two percent of the hospitals (n=78) were located in metropolitan areas (RUCC 1-3). Hospitals ranged in size from 6 hospital beds to 1,109 beds (mean=245, median=134). Sixty-one percent (n=58) were faith-based nonprofit hospitals and 84 percent (n=80) were part of a larger healthcare system.

Report characteristics. The majority of the reports (82 percent; n=78) were conducted and published in 2013, with 13 percent (n=12) published in 2012 and 5 percent (n=5) in 2011. Forty-five percent of the CHNA processes were staff-led; 55 percent were consultant-led (n=43; n=52). Contrary to the IRS requirements, only 13 percent of the reports (n=12) evaluated collaborated with a local health department in a meaningful way.

Evaluation criteria. Each evaluation criterion ranged widely on the 6-point scale (0=not addressed; 5=high quality). The criteria with the highest means scores were examination of the data using reliable sources and multiple data collection sources and methods (3.35), the feasibility and sustainability of plans (3.14), and report readability and accessibility to the public (3.01). The criteria with the lowest mean scores were the identification of issues and/or strategies that considered social determinants of health (1.15), use of evidence-based strategies (1.34), consideration of local contextual factors

(1.40), and examination of contributing causes to health issues (1.70). Table 2.2 shows the range and mean of each evaluation criteria item.

Table 2.2.
Range and Mean for Evaluation Criteria Items

Criteria Item	Range	Mean
Partner/Stakeholder involvement	1-5	2.50
Organizational Structure/ Personnel	1-5	2.38
Define Community	1-5	2.92
Examination of Data (data source, methods)	1-5	3.35
Identify/Prioritize Issue(s)	1-5	2.84
Examine Causation of Problem	0-4	1.70
Considers local context	0-5	1.40
Identify Assets/Resources	0-5	2.93
Clear Goals/Measurable Objectives	0-5	2.23
Action Plan/Strategies to address issue	0-4	2.51
Evidence-based strategies	0-5	1.34
Issue/strategy-type: reflects social determinants of health	0-4	1.15
Description of the Process	0-5	2.56
Feasibility/Sustainability	0-4	3.14
Evaluation	0-4	2.22
Accessibility	1-5	3.01
Total Score	**11-61**	**38.2**

Total score. Using the summative values of 16 evaluation criteria items, total report scores ranged from eleven to sixty-one (possible high=80). The mean total score was 38.2; the median total score was 40.0. The majority of reports fell in the mid-scoring range: 16 report scores (16.8%) ranged from 11-27; 49 report scores (51.6%) ranged from 28-46; and 30 hospital CHNA/implementation strategies report scores (31.6%) ranged from 47-61.

Associations Among Hospitals, Reports, Evaluation Criteria, and Total Scores

Some strong variable correlations were expected; presence of local health departments, larger hospitals, and higher median county income had positive associations with urbanity (ρ=0.6581; ρ =0.4043; ρ=0.5996). Faith-based hospitals were more likely to be part of a healthcare system versus a stand-alone facility (ρ=0.4829). The year the assessment was conducted was strongly associated with hospital location and median county income (ρ=0.4985; ρ=0.5558); interestingly, nonmetropolitan-based hospitals and lower income counties were likely to conduct an earlier assessment (in 2011 or 2012).

Consultant-led assessments were positively associated with how well the CHNA process was described (ρ=0.4549) and report readability and accessibility to the public (ρ=0.5449). Collaborating with a local health department had a strong, positive association with involvement of partners and stakeholder in the CHNA process (ρ=0.5896) and examining contributing causes of problems (ρ=0.4867). Faith-based hospitals had a strong, negative association with report readability and accessibility to

the public (ρ=-0.4100) and the extent to which hospitals appeared to provide organizational support and personnel for the CHNA process (ρ=-0.4696).

Hospital characteristics, including hospital size and system-based hospitals, had very weak, positive associations with the total CHNA/implementation strategies report score (ρ=0.0467, ρ=0.0338). Metro-located hospitals had a moderately weak, positive association with the overall report score (ρ=0.1086), while faith-based hospitals had a moderately weak, negative association with the overall report score (ρ=-0.1285). The presence of a county or city health department had a very weak, positive association (ρ=0.0163) and median county income had a moderately weak, positive association (ρ=0.1175) with the total report score. Characteristics of the report had somewhat stronger relationships to report quality: consultant-led assessments and collaborating with a local health department to conduct the assessment were positively associated with total scores (ρ=0.3362; ρ=0.2542). The year the assessment was conducted had a very weak, positive association with total CHNA score (ρ=0.0262).

Most report evaluation criteria were strongly associated with total CHNA score. Those most strongly associated with total score were identification of existing assets/resources to contribute to health needs (ρ =0.7872), identification of issues and/or strategies that considered social determinants of health (ρ=0.7618), examination of contributing causes to problems (ρ =0.7434), creation of action plans and strategies to address identified issues (ρ=0.6974), identification of evidence-based strategies (ρ=0.6965), examination of the data using reliable data sources and multiple data collection sources and methods (ρ=0.6612), development of an evaluation plan (ρ

=0.6543), developemnt of clear goals and measureable objectives (ρ=0.6402), and feasibility/sustainability of plans (ρ=0.6254). While most of the evaluation criteria were strongly associated with the assessment report total score, some correlational variations may suggest some factors are more important to overall quality and provide evidence for weighting these criteria in future studies.

Factors with Substantial Influence on Total Score

Independent variables with little influence on the total score were removed from the model to reduce relationship complexity and avoid distortion by extraneous variables (p-values >.25). See Table 2.3 for the univariate analysis summary of all variables. The full model was fit with the remaining possible predictors. The final model, which included the independent variables staff-led CHNA processes and collaboration with a local health department, fit significantly better than the intercept only model $F(2, 92) = 16.19$, p-value =0.0000, $R^2 = 0.2918$). The final model accounted for 29.2% of the variability in the total report score. See Table 2.4 for the final model with adjusted and unadjusted regression coefficients and 95% confidence intervals. Using this model, staff-led community health needs assessment processes were associated with a 10.3-point decrease in total CHNA/implementation strategies report score (CI = -14.22537 – -6.390098). Partnering with a local health department was associated with a 12.1-point increase in total report score (CI = 5.617092 –18.62217).

Discussion

While the initial evaluation was limited to Texas nonprofit hospitals, these results provide preliminary insight to understanding nonprofit hospitals' approach to the draft

requirements. Results suggest collaborating with a local health department and working with a consultant appear to improve CHNA/implementation strategies report quality. Given that we largely used a public health model to evaluate the reports, a strong association between quality and local health department partnerships might be expected. We might expect communities with more local resources to have a higher-quality assessment reports. However, variables presumably indicative of high resource areas, such as the presence of a local health department, higher median income, larger hospital, healthcare system membership, and metropolitan-located hospitals, had relatively weak associations. This study suggests consultants, at least at this point in time, may be better suited to lead community health needs assessments than hospital staff. Traditionally, hospitals have viewed health through the lens of treating sick patients as opposed to promoting health and preventing disease at the population-level.

Table 2.3.
Summary of Univariate Analysis for All Variables

Variables	n	F	LR	P	R2	AIC	BIC
Staff-led	95	16.40227	15.43105	.000106***	.1499262	699.9147	705.0225
Partnered with LHD	95	6.084728	6.020703	.0154667*	.0614093	709.3251	714.4328
Faith-based hospital	95	2.441325	2.461656	.121573	.0255793	712.8841	717.9919
Hospital size	95	.5023405	.5117626	.4802464	.0053725	714.834	719.9418
Metro	95	.3834641	.3909053	.5372692	.0041063	714.9548	720.0626
Year	95	.0527114	.0538298	.8189148	.0005665	715.2919	720.3997
Health care system member	95	.0419957	.0428892	.8380758	.0004514	715.3029	720.4106
Median County Income	95	.0309696	.0316303	.8606909	.0003329	715.3141	720.4219
LHD in county/city	95	.0148948	.0152139	.9031273	.0001601	715.3306	720.4383

* = P<.05, ** = P<.01, *** = P<.001

Table 2.4.
Final Model with Unadjusted and Adjusted Regression Coefficients

Variable	Unadjusted (95% CI)	Adjusted (95% CI)
Staff-led	-7.955277 (-12.03275 – -3.8778)	-10.30774 (-14.22537 – -6.390098)
Partnered with local health department	7.628514 (.7117427 -- 14.54529)	12.12004 (5.617092 – 18.62217)

F= 16.19, p-value =0.0000, R^2 = 0.2918

The strategies identified in the implementation strategies reports were largely composed of activities in which hospitals were already involved. It is not known to what extent hospitals may build on or expand these activities, rather than continue business as usual. Many implementation strategies reports included Medicaid 1115 Waiver Delivery System Reform Incentive Program (DSRIP) or similar-type projects. As the name suggests, hospitals are incentivized for meeting DSRIP project milestones. While some DSRIP project areas have potential to impact population health, the vast majority are medical interventions focused on patients care (TMF Health Quality Institute, 2012, April 10).

There is a newfound focus on population health in healthcare through various policies and healthcare initiatives, including the Institute for Healthcare Improvement triple aim, primary care and public health integration, Accountable Care Organizations, the Prevention and Public Health Fund, and new community benefit requirements for nonprofit hospitals. This health assessment and planning process and the draft regulations provide an opportunity to begin making such improvements (Berg, 2009; Hacker & Walker, 2013; Nobles & Casolino, 2013). Nonetheless, hospitals struggled to

include, or altogether excluded, issues and strategies that reflected and accounted for broader social determinants of health. Hospital reports also performed poorly in identifying evidence-based strategies to address health issues, considering local contextual factors, and examining contributing causes to problems. If we are to hope for population health improvements through these methods, hospitals cannot continue to do what they are doing.

This is not to suggest hospitals select issues and implement strategies outside the scope of their mission and capabilities. Health and social issues are intertwined and incredibly complex. Single-shot, unilateral approaches to health issues are not generally successful (Wimberley, 2008). Policies and programs, largely due to lack of resources, frequently offer superficial solutions to these issues rather than recognize that health issues are the result of social and economic inequalities. The vagueness of the draft regulations and similarities with other assessment activities (e.g., FQHC needs assessment, local health department accreditation) provide opportunities for hospitals to create strategic partnerships with public health systems, social service agencies, and other public and private agencies and organizations. Rosenberg referred to hospitals as "a necessary community institution strangely insulated from the community" (Rosenberg, 1987, p. 349). However, these regulations provide an opportunity for hospitals, agencies, and other organizations to escape their disciplinary silos, align assessment processes, share data and resources, and enhance organizational and disciplinary strengths. At the time of this study, the IRS had not issued the final regulations. This provides an opportunity for the federal government to strengthen and

clarify the guidance, the purpose of the health assessment and planning processes and CHNA/implementation strategies reports, and the roles of public health and other community stakeholders.

Limitations

Findings should be interpreted with caution due to the scope of the study and sample size. This study is a representation of CHNA/implementation strategies reports in Texas and accounted for approximately fifty-three percent of the nonprofit hospital population in Texas. While limited to Texas, we think these results are applicable to nonprofit hospitals in other states.

The variables in the regression model have wide confidence intervals. A larger sample of hospitals, preferably in multiple states, should be used to replicate the study. Relationships in the regression model are limited to the independent variables included; other factors important to report quality may not have been considered. Such contextual factors will be investigated in greater depth in phase II. Finally, this was an initial step in evaluating reports with one primary evaluator. In future studies, one or more independent evaluators should review reports to measure and enhance inter-rater reliability.

A strong predictor of report quality was partnering with a local health department; only thirteen percent of hospitals truly collaborated with a city or county health department to conduct the CHNA. However, we excluded some assessments in this study due to partial completion. Several of the excluded reports involved multi-organizational and agency collaborative processes. One might speculate that assessment

processes involving multiple organizations and agencies would take longer and, thus, the full reports were not available at the time of CHNA/implementation strategies report evaluation. As a greater number of complete reports become publicly available for comparisons, we will have a still better understanding of nonprofit hospitals' approach to community health needs assessment.

CHAPTER III

A MIXED METHODS APPROACH TO UNDERSTANDING COMMUNITY PARTICIPATION IN COMMUNITY HEALTH NEEDS ASSESSMENTS

Introduction

The Patient Protection and Affordable Care Act of 2010 (ACA) includes a provision requiring all nonprofit hospitals to conduct a community health needs assessment (CHNA) at least every three years. For the first three-year reporting period, nonprofit hospitals used draft regulations issued by IRS, as regulations had not been finalized. These draft regulations required hospitals to define the service community, conduct a CHNA, prioritize community health needs, and develop a plan to address these issues (IRS, 2013, April 5). In addition, the draft regulations required hospitals take into account input from stakeholders with public health knowledge and expertise as well as leaders, representatives, or members of medically underserved, low-income, and minority populations in the community. It is this last component relating to community involvement that is the focus of this article.

Two factors may influence this legislation's ability to influence population health: (1) the financial accountability tied to the legislation and (2) the mandate to collaborate with public health-related agencies and other community stakeholders. The IRS regulation is linked to and enforced by the IRS; noncompliance results in a $50,000 fine and possible tax-exempt status revocation (IRS, 2013, April 5). Nonprofit hospitals might also risk their community standing if they simply chose to be noncompliant.

Finally, the regulation requires the involvement of public health agencies and other organizations in the completion of a health assessment and process to address identified needs (IRS, 2013, April 5).

The broader purpose of this mixed methods study was to better understand how nonprofit hospitals were approaching this relatively new IRS requirement. Phase I of this research study, which involved a broad-based evaluation of CHNA/implementation strategies reports, guided the research questions, case selection, and interview questions. Phase II explored this approach in greater depth by conducting interviews and secondary reviews of CHNA/implementation strategies reports. The research question for this article is to what the extent do the draft regulations as implemented by nonprofit hospitals in Texas actually engage and mobilize local communities.

Community Participation: Definitions and Purpose

Community participation has become a major component of public health approaches to improving population health. While there is no single, widely agreed-upon definition, community participation can be defined as "active involvement of a diverse network of community members" for the purpose of "improving their own and their community's health and well-being" (Goodman et al., 1998; p. 262; Public Health Agency of Canada, 2007, p. 1). Research suggests community participation is an essential component for creating effective and sustainable public health programs (Roussos & Fawcett, 2000; Shortell et al., 2002). Involvement of the community can provide diverse perspectives and help improve cultural sensitivity, reliability, and validity, assuming there is quality community participation (Minkler, 2005). Community

participation emphasizes locally relevant problems and approaches to addressing health problems (Israel, Schultz, Parker & Becker, 1998; Leung, Yen & Minkler, 2004). Community participation can build capacity for future collaboration and problem-solving (Bess, Prilleltensky, Perkins, & Collins, 2009; Israel, Schulz, Parker, Becker, 1998; Israel, Schulz, Parker, Becker, Allen, Guzman, 2008; Minkler, 2005; Wallerstein, 1999). Ideally, community participation efforts will recognize, respect, and further develop naturally occurring capacities, sense of belonging, common purpose, and the degree to which individuals feel connected (Eng, Hatch, & Callan, 1985; McLeroy, Norton, Kegler, Burdine & Sumaya, 2003; Steuart, 1975).

Internal Revenue Services Standards

The IRS requirements mandate some amount of community participation. At a minimum, nonprofit hospitals must "take into account input from persons who represent the broad interests of the community served by a hospital facility" and "take into account input from:

> (1) Persons with special knowledge of or expertise in public health;
>
> (2) Federal, tribal, regional, State, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and
>
> (3) Leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility" (IRS, 2013, April 5).

However, the guidance is vague and does not specify the intensity or extent of community engagement nor what activities stakeholders should be involved and the extent to which their input should be considered.

Community Participation Frameworks

Among experts, there are different ways to frame community participation (Baum & McDougall, 1995; Charles & DeMario, 1993; Dwyer, 1989; Granner & Sharpe, 2004; Llewellyn-Jones & Harvey, 2005; Rifkin, 1986). A frequently cited framework to describe levels of community participation is Arnstein's "Ladder of Citizen Participation" (Arnstein, 1969). Eight ladder rungs describe three categories of participation: non-participation, tokenism, and citizen power. While Arnstein's model is often used to analyze community participation, it does not appear to be a particularly useful model for assessing the degree of community involvement in these nonprofit hospital health assessment and planning processes.

Beyond level of participation, we found other community participation factors important to consider. By using a participatory evaluation framework, we were able to examine and frame community participation in the health assessment and planning processes through three dimensions of community engagement, including:

- Control of decision-making
- Selection for participation
- Depth of participation

(Cousins, Donohue, & Bloom, 1996; Cousins & Whitmore, 1998; Cullen & Coryn, 2011). The control of decision-making dimension considers whether decisions and

processes are controlled by experts, controlled by stakeholders and the community, or control is balanced (Cousins, Donohue, & Bloom, 1996). Selection for participation is a dichotomous dimension that includes all legitimate groups or restricts involvement to primary users (Cousins & Whitmore, 1998). Primary users are made up of a narrower group who has a vital interest in the process. The last dimension, depth of participation, ranges from extensive participation to moderate participation to no participation or consultation only when requested (Cousins, Donohue, & Bloom, 1996; Cousins & Whitmore, 1998). The purpose of this mixed methods study is to better understand the intensity of community engagement in the health assessment and planning processes, and the likelihood that the strategies employed, will succeed in mobilizing communities and building community capacity.

Methods

Research Design

There are numerous definitions of mixed methods research. A composite definition developed by Johnson, Onwuegbuzie, and Turner, describes mixed methods research as "the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and corroboration" (2007 p. 123). There are many advantages of and rationales for mixed methods research. Triangulation corroborates findings and strengthens validity (Greene, Caracelli & Graham, 1989). Complementarity capitalizes on the strengths and compensates for weaknesses of quantitative and qualitative methods and "provides better understanding of research problems than either

approach alone" (Creswell & Plano Clark, 2007, p.5; Greene, Caracelli & Graham, 1989; Small, 2011). Development uses one method to inform or help develop the other method (Greene, Caracelli & Graham, 1989). Through initiation, new explanations and interpretations can emerge by analyzing findings "from different perspectives of different methods or paradigms" (Greene, Caracelli & Graham, 1989, p. 259). Expansion enhances inquiry by using the most appropriate method for different research components to produce more complete knowledge (Greene, Caracelli & Graham, 1989; Johnson & Onwuegbuzie, 2004). Finally, mixed methods are a way to explore a topic about which little is known (O'Cathain, Murphy, & Nicholl, 2007).

Despite advantages of mixed methods research design, there are numerous criticisms. This is discussed in greater detail by others, but the essential disagreements are attributed to three interrelated issues: 1) concerns about paradigm incommensurability, 2) the definition of paradigm, and 3) distinctions between paradigms, methodologies, and methods (Bergman, 2010; Greene, 2006; Guba, 1990; Guba & Lincoln, 1994; Guba & Lincoln, 2005; Johnson & Onwuegbuzie, 2004; Johnson, Onwuegbuzie & Turner, 2007; Morgan, 2007; Tashakorri & Creswell, 2007). Despite growing support for the pragmatic approach as a guiding paradigm for mixed methods research, criticism continues (Johnson & Onwuegbuzie, 2004; Morgan, 2007; Tashakkori & Teddlie; 2003).

To address some of the concerns surrounding mixed methods research, we examined and acknowledged our biases and attempted to address some of these using parallel criteria (Guba & Lincoln, 1989). See Appendix A for the research team

subjectivity statement. Figure 3.1 illustrates the conceptual research design, in which quantitative and qualitative findings informed stages throughout the study process. Phase I consisted of reviewing ninety-five CHNA/implementation strategies reports. In phase II, we interviewed key informants, consultants, and community stakeholders involved health assessment and planning processes. An overview of phase I quantitative methods and phase II qualitative methods are provided below. We received approval for this study from the Texas A&M University Office of Research Compliance Human Subjects Protection Program.

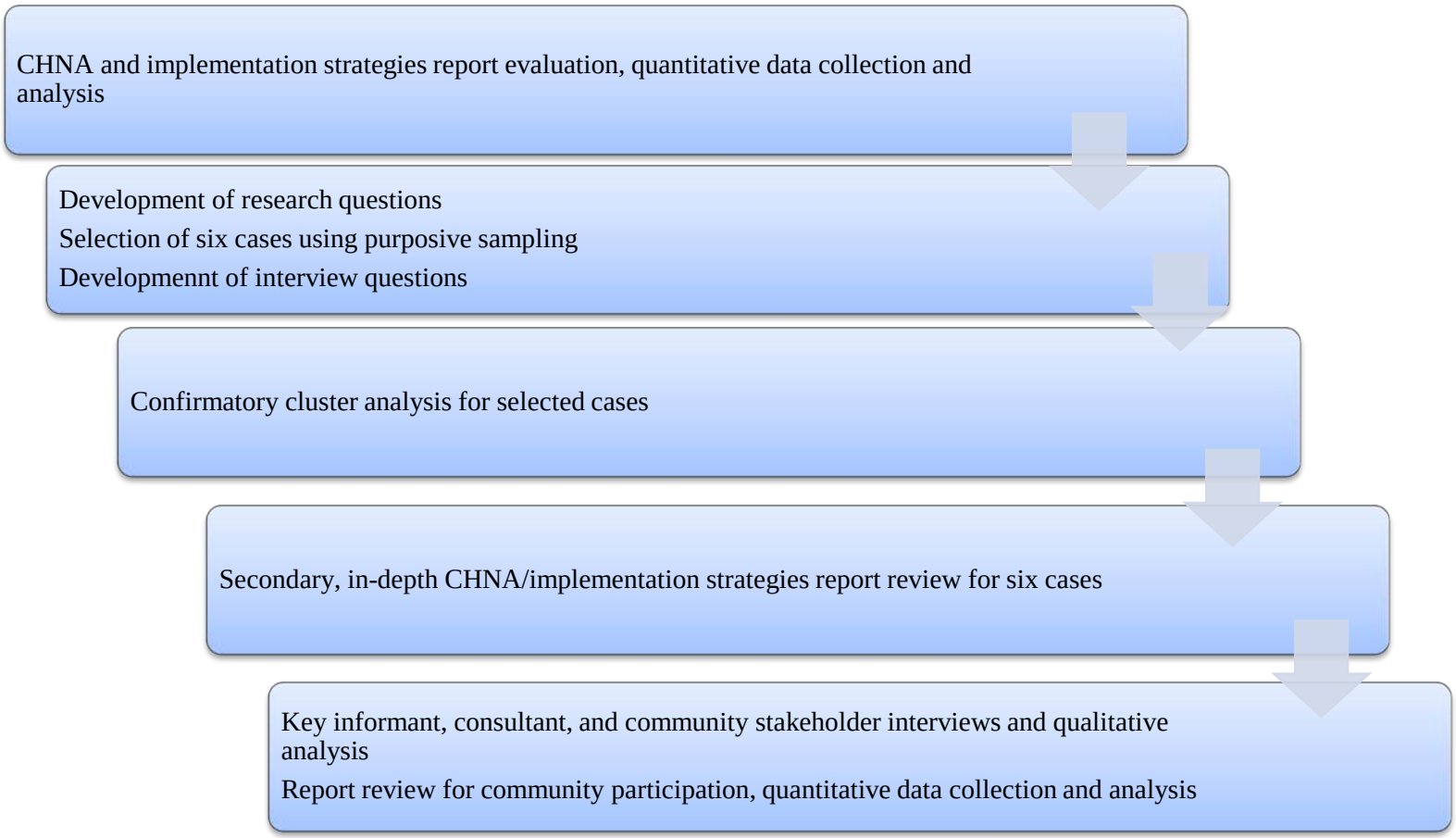
Phase I: Quantitative Methods

Data collection. We accessed publicly available CHNA/implementation strategies reports through web-based searches. We reviewed, evaluated, and scored ninety-five (n=95) reports using sixteen evaluation criteria items. A more detailed description of phase I methods can be found elsewhere, which can be obtained from the lead author (Pennel, McLeroy, Burdine, and Matarrita-Castante, 2014).

For this portion of the study, reports were reviewed for the evaluation criteria item representative of community participation, partner/stakeholder involvement. Specific to partner/stakeholder engagement, reports were evaluated using a six-point scale, borrowing from a scale used to assess state plans for obesity prevention (Butterfoss & Dunet, 2005; Dunet, Butterfoss, Hamre, & Kuester, 2005).

Figure 3.1: Conceptual Framework for Research Design

Study purpose: Understand nonprofit hospitals' approach to CHNA/implementation strategies requirements



Partner and stakeholder engagement was evaluated on:

- Meaningful stakeholder involvement and community engagement (Barnett, 2012; Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005)
- Collaboration with community agencies/organizations external to the hospital (CHA, 2013; IRS, 2013, April 5; Parra-Medina, Taylor, Valois, Rousseau, Vincent & Reininger, 2003; Sridharan, Go, Zinzow, Gray, Gutierrez Barrett, 2007)
- Description of planned collaborations to address health needs between the hospital and other facilities or organizations (IRS, 2013, April 5)
- Formation of an assessment team or advisory committee with community representatives (CHA, 2013)
- Representation that is balanced and reflects community (seek community input that reflects the racial, ethnic and economic diversity of the community) (Butterfoss & Dunet, 2005; CHA, 2013; Dunet, Butterfoss, Hamre, & Kuester, 2005; IRS, 2013, April 5).
- Communication mechanism between stakeholders (Sridharan, Go, Zinzow, Gray, Gutierrez Barrett, 2007)
- Shared ownership of process and outcomes (Barnett, 2012)
- Shared accountability and regional governance (Barnett, 2012)
- Validation of priorities with community input (CHA, 2013)

- Involvement of community stakeholders and community members in primary data collection (focus groups, interviews, surveys, and/or summits) and selection of priorities and/or strategies (CHA, 2013)
- Potential for building community capacity (Goodman et al., 1998)

Partner/stakeholder engagement that was not addressed was scored zero; engagement that was low quality or had no detail was scored one; engagement that was low quality and included very limited detail was scored two; engagement that was partially or variably addressed was scored three; engagement that was sufficiently addressed (good, solid job) was scored four; and engagement that was addressed with high quality and detail was scored five.

Also, ninety-five CHNA/implementation strategies reports were reviewed and assessed based on *types* of community participation activities hospitals in which hospitals engaged community stakeholders. Eight types of community participation activities were identified: no attempt to engage community stakeholders; only engaged health-related stakeholders to represent community members in surveys, interviews, and/or focus groups to identify health needs; engaged broader community stakeholders to represent community members in surveys, interviews, and/or focus groups to identify health needs; engaged community members in surveys, interviews, and/or focus groups to identify health needs; verified or validated health needs or priorities with community stakeholders; involved community stakeholders in priority identification or ranking; involved community stakeholders in strategy selection; and involved community stakeholder or partnerships in carrying out strategies.

Analysis. Descriptive statistics for stakeholder involvement criteria, including range, median, and mean, were generated. The eight community participation activities identified in the ninety-five CHNA/implementation strategies reports were also quantified. Finally, we used Spearman rank correlation to determine relationships between partner/stakeholder involvement and other variables. Data analysis methods are described in more detail in Pennel, McLeroy, Burdine, and Matarrita-Castante (2014). We used Stata version 12 to conduct analyses (StataCorp LP, College Station, TX).

Phase II: Qualitative Methods

Case selection. Using purposive sampling, we selected six cases of the ninety-five reviewed in Phase I. Selection criteria included the total score, which represents CHNA report quality; hospital location; hospital size; faith-based affiliation; health care system member; staff- or consultant-led CHNA report; and CHNA reports conducted in collaboration with a local health department. However, the primary categorical criteria were CHNA report total score, using a high, medium, and low-scoring rubric, and hospital location (metropolitan or nonmetropolitan). Thus, within each scoring category, there was one metropolitan-based case and one nonmetropolitan-based case. One to eight alternate cases with similar characteristics were designated should selected hospitals decline to participate. Selection based on these factors, in part, contributed understanding to how nonprofit hospitals in different environments with different resources approached the IRS requirement. Further, selecting a range of contrasting cases added confidence to findings (Miles, Huberman, & Saldana, 2013, p. 33). In order

to verify the case sampling strategy, we conducted confirmatory cluster analysis to verify the range of contrasting cases selected using key selection criteria.

Participants. Among the six sites, sixteen people were interviewed: nine key informants, three system-level and six hospital-level; three consultants; and four community stakeholders. Table 3.1 provides more detailed information about interview participants. Key informants and consultants were primarily identified using the CHNA/implementation strategies reports, which typically included the key contacts for the reports. For the six sites, we contacted ten key informants and three consultants. Only one key informant could not be reached due to accepting a job with a different organization in a different city.

The types of key informants varied for the six selected sites. Hospitals in health care systems had system-level units responsible for community benefits, who were the key contacts for the assessment and planning processes. We also asked system-level key informants to identify hospital-level key informants with whom we should speak. Key informants at the hospital-level often served in marketing and community relations roles. Key informant contacts in smaller, non-system-based hospitals were consultants and/or CEOs. All selected hospitals agreed to participate. Key informant and consultant interviews lasted forty to sixty minutes.

We used snowball sampling by asking key informants and consultants for referrals to external stakeholders involved in the health assessment and planning processes. When names were provided, these external partners were contacted and requested an interview. In addition, community stakeholders referenced in

CHNA/implementation strategies reports or stakeholders we would expect to be involved in the processes were contacted, particularly for sites that did not refer any community stakeholders. This provided perspectives from stakeholders that were not as closely tied to hospitals as stakeholders key informants identified. Among the six sites, we contacted fourteen community stakeholders and completed interviews with four. Three community stakeholders, representing local public health agencies, did not think they had much information to contribute due to their lack of involvement in the health assessment and planning processes. While these stakeholders were not interviewed, they received study information and informed consent and waived documentation of consent. The information they provided, relating to lack of involvement, was revealing. The remaining community stakeholders contacted did not return phone calls and emails. Community stakeholders included representatives of a Federally Qualified Health Center, a health department/district, county YMCA, and a faith-based nursing ministry. Community stakeholder interviews ranged from twenty to forty minutes. A summary report of findings will be shared with all participants.

Data collection. We conducted semi-structured interviews with key informants, consultants, and community stakeholders during March-May 2014, using an interview guide with open-ended interview questions and a flexible interviewing technique. Flexible interviewing allows the interviewer to deviate from the original wording and freedom to probe and follow-up on responses (Groves, Fowler, Couperm, Lepkowski, Singer, & Tourangeau, 2009). While standard questions were asked, this allowed us to

Table 3.1.
Data Sources

Hospital Site	Key Informant Interviews	Community Stakeholders Interviews	Document Sources
1	CEO	----	Hospital Community Health Needs Assessment (implementation plan incorporated into CHNA)
2	Community Benefits Manager (system-level)	Public Health Official*	Hospital Community Health Needs Assessment Hospital Community Benefit Implementation Plan
3	Consultant 1 Consultant 2 CEO	Public Health Official*	Hospital Community Health Needs Assessment and Implementation Plan
4	Community Benefits Manager (system-level) Marketing/Public Relations Manager (hospital-level)	FQHC CEO Public Health Official*	Hospital Community Health Needs Assessment Hospital Implementation Plan
5	Marketing/Public Relations Manager Consultant	YMCA CEO Faith-based Nurse	County Community Health Needs Assessment CHNA Update (December 17, 2014)
6	Community Benefits Manager (system-level) Marketing/Public Relations Manager (hospital-level) CNO (hospital level)	Public Health Official	County Community Health Assessment Hospital Implementation Strategy

* We contacted these community stakeholders by telephone and email. They were willing to participate in an interview but did not think they had anything to add due to their lack of involvement in the assessment and planning process. They received study information and informed consent and documentation of consent was waived.

probe and clarify. We developed three different sets of interview questions, guides, and informed consents: one for health system and hospital key informants, one for consultants, and one for community stakeholders. Questions were created for each group to aid triangulation and validation. CHNA reports and phase I findings also informed interview questioning. Prior to conducting interviews, three professionals, known to the research team, with heath care systems expertise reviewed the interview questions for content validity and provided feedback on usefulness and relevance of the questions. Irrelevant, non-essential questions were eliminated. Appendix B includes the three sets of interview questions.

Interviews were conducted face-to-face when permitted, and were otherwise conducted by telephone. A Skype interview option was also provided to interviewees. A consent form along with information about the study was distributed at initial contact and re-sent prior to the interview. Hard copies of the consent forms, stored separately from data, were retained in a locked file cabinet. When permission was granted, interviews were audio recorded using an Olympus digital voice recorder. All interviewees consented to audio recordings. Audio recordings were transcribed by a professional transcription service. Upon receipt of transcripts, they were reviewed for accuracy and de-identified.

Prior to each interview, we reviewed the CHNA/implementation strategies reports for selected sites again to provide greater insight into the process and better guide our interview approach and probes. Immediately following each interview, we completed site-specific memos with reflections about the interview based on the

information provided, the CHNA/implementation strategies reports, and key points or themes that emerged. In addition, any documents provided by interviewees were reviewed for relevance, de-identified, and saved for analysis. Case summaries for each site were developed.

We created a database to organize and document sources, data, and interpretations of data using QRS NVivo 10. Data sources imported into the program included the de-identified interview transcripts, site memos, CHNA/implementation strategy reports, case summaries, and other relevant documents, emails, or notes. We used interviewee and potential interviewee rationale and tracking procedures in Microsoft Excel and decision logs in Microsoft Word to document processes, interpretations, and decisions within and between phase I and phase II.

Analysis. We used the constant comparative analysis method – an iterative process that involved concurrent data collection and analysis, followed by preliminary coding of data, categorizing based on codes, and developing preliminary broad themes or concepts. While originally proposed by Glaser and Strauss (1967) for use in grounded theory studies, the constant comparative analysis method can be used throughout qualitative research (Merriam, 2009). Based on the phase I review of the CHNA/implementation strategies reports, the secondary, in-depth report reviews for the six cases, and initial interviews, community participation emerged as a construct that varied widely between reports and cases.

Using phase I findings, we developed a general continuum of community participation. We searched for and evaluated community participation theoretical

frameworks to guide data analysis and interpretation and provide analytical parameters (Anfaran & Mertz, 2006; Wu & Volker, 2009). To provide this theoretical foundation, we anticipated using Arnstein's ladder of participation. However, due to the lack of variation in community participation between the six cases, we decided the participatory evaluation model provided a better comparative framework to analyze and understand variations in community participation across the six cases (Cousins, Donohue, & Bloom, 1996; Cousins & Whitmore, 1998; Cullen & Coryn, 2011).

While the interviews generated a large amount of data, we focused on elements related community participation and the participatory evaluation framework dimensions to answer the research question of interest. Community participation-related items in interview transcripts, CHNA/implementation strategies reports, and memos were coded and placed in preliminary categories. We also coded items that aided contextualization of community participation activities (e.g., value placed on participation). Community participation profiles were constructed for each case.

Next, using the three participatory evaluation dimensions, control of decision-making, selection for participation, and depth of participation, we conducted cross-case analysis and coded components related to community participation for these dimensions. Data were coded using QRS NVivo 10 qualitative software. Naturalistic generalization was used in cross-case analysis to identify similarities and differences in case study details based on our experiences and reflections on the details and descriptions presented in the case profiles (Stake, 1995). See Appendix C for site descriptions and Appendix D for site memos.

Trustworthiness and Rigor

Several data collection, maintenance, and analysis methods were used to judge the adequacy of the study. Trustworthiness, or parallel criteria, "are intended to parallel the rigor criteria that have been used within the conventional [scientific] paradigm" (Guba & Lincoln, 1989, p. 233). Trustworthiness involves establishing credibility, transferability, dependability, and confirmability. To strengthen credibility, we primarily relied on triangulation, by using different data collection methods and sources (Guba & Lincoln, 1989). We also conducted interviews with key informants, consultants, and community stakeholders to confirm the accuracy of the conclusions drawn from CHNA and implementation strategies report interpretations (Yin, 1994). Case study methodology is not necessarily meant to be generalizable to a broader population, but to aid transferability, we selected a range of six case studies to provide a range of contrasting cases and help understand findings in multiple contexts. Purposive sampling was also used to strengthen transferability (Guba & Lincoln, 1989; Teddlie & Yu, 2007).

To enhance dependability and confirmability, we created a database to organize and document sources, data, and interpretations of data in QRS NVivo 10. (Guba & Lincoln, 1989; Yin, 1994). Sources imported into the program included the phase I de-identified interview transcripts, site memos, CHNA/implementation strategy reports, case summaries, and other relevant documents, emails, or notes. We used interviewee and potential interviewee rationale and tracking procedures in Microsoft Excel and decision logs in Microsoft Word to document processes, interpretations, and decisions within and between phase I and phase II. Conversation notes and relevant emails from

national-level experts were also imported into QRS NVivo 10. Two co-authors and research team members met weekly to discuss progress, address questions that arose throughout the process, and assess findings and interpretations (Yin, 1994; Guba and Lincoln, 1989).

Results

Phase I: Quantitative Results

In this article, we report data and analyses specifically related to community participation and stakeholder involvement; broader study findings will be reported elsewhere.

Descriptive statistics. Table 3.2 provides descriptive statistics of the partner/stakeholder involvement criteria. Because there was a minimum level of partner/stakeholder involvement nonprofit hospitals had to meet, no hospitals scored a zero. However, only 14.7 percent (n=14) scored a four or five on the six-point scale.

Table 3.2.
Partner/stakeholder Involvement Statistics

Score	Frequency	Percent
0	0	0.0
1	13	13.7
2	40	42.1
3	28	29.5
4	10	10.5
5	4	4.2

Activities in which community stakeholders participated varied across the ninety-five health reports. While the draft regulations required a minimum level of participation, eighteen percent (n=17) of the CHNA report processes made no attempt to engage community stakeholders. This most often occurred when existing assessment documents were used to supplant any original primary data collection methods. The majority (80 percent; n=76) of CHNA processes engaged broader community stakeholders to represent community members in surveys, interviews, and/or focus groups to identify health needs. These frequently included community-based organizations and local governmental agencies, such as public schools, youth/older adult-serving organizations, local elected officials, and organizations that represent low-income and underserved community members. More than one-quarter of the CHNA processes involved community members in surveys, interviews, and/or focus groups to identify health needs (28 percent; n=27). Surveys were often disseminated electronically, but occasionally paper-based surveys were placed in locations to reach underserved populations. Only two CHNA report processes (2 percent) requested input solely from health-related community stakeholders to identify health needs. Twenty CHNA report processes (21 percent) verified or validated health needs or priorities with community stakeholders. Four CNHA report processes (4 percent) involved community stakeholders in priority identification or ranking. Only two (2 percent) involved community stakeholders in strategy selection. Two CHNA report processes (2 percent) involved community stakeholder or partnerships in carrying out strategies. See table 3.3.

Associations among stakeholder involvement and other characteristics.

Using Spearman rank correlation, partnership/stakeholder involvement had strong positive associations with collaborating with a local health department on the CHNA (ρ=0.5896), examining contributing causes of problems (ρ= 0.4559), considering local contextual factors (ρ = 0.4569**),** describing the CHNA process (ρ=0.4103), and the CHNA report total score (ρ=0.4138). This supports previous research that involving community members in community assessment and planning activities enhances identification of broader social determinants of health and of community-specific, contextual factors that may improve program effectiveness and sustainability

Table 3.3.
Community Health Needs Assessment and Implementation Strategies Community Engagement Activities

Depth of Participation	CHNA Community Engagement Activities*	Frequency	Percent
No participation/ Consultation-only	No attempt to engage community	17	18%
	Community engagement to identify health needs through surveys, interviews, and/or focus groups: • Health-related community stakeholders only	2	2%
	• Broader community stakeholders	76	80%
	• Community members	27	28%
	Verify/validate health needs/priorities with local experts	20	21%
Moderate Participation	Community stakeholders involved in priority identification	4	4%
	Community stakeholders involved in strategy selection	2	2%
Extensive Participation	Partnerships developed to carryout strategies	2	2%

* CHNA community engagement activities are not mutually exclusive

(Israel, Schultz, Parker & Becker, 1998; Leung, Yen & Minkler, 2004; McLeroy, Bibeau, Steckler, & Glanz, 1988; Roussos & Fawcett, 2000; Shortell et al., 2002).

Case selection. All six hospitals agreed to participate, so no alternate cases were used. Table 3.4 provides descriptive statistics, including range, mean, and median for confirmatory cluster analysis for selected cases. When complete linkage results for three groups were compared to the pre-cluster selected cases, cases were distributed in the three groups: 2 in low-scoring, 2 in medium-scoring, and 2 in high-scoring per complete linkage clusters. When pre-cluster groups were compared to the 6-group complete linkage results, the pre-cluster selected cases were in 5 of 6 complete linkage clusters. Table 3.5 provides hospital and report characteristics for the six selected cases.

Phase II: Qualitative Results

Using interviews, reviews of CHNA/implementation strategies reports, and phase I findings, we evaluated community participation dimensions of the draft regulations and health assessment and planning processes through the participatory evaluation framework. These results informed the extent to which processes resulting from the draft regulations have potential to mobilize communities and build capacity.

Control of decision-making. Cousins, Donohue, and Bloom (1996) differentiate control of decision-making by who controls the process and makes the decisions: expert control, stakeholder/community control, or balanced control. The draft regulations only require hospitals take into account input from those with public health expertise and members of or representatives for medically underserved, low-income, and minority populations. It is not known how the IRS intended nonprofit hospitals to interpret this for

Table 3.4.
Confirmatory Cluster Analysis Results

Quality Score Level	Pre-Cluster Frequency	Pre-Cluster			Kmeans Cluster	CompLink Cluster (3 groups)			CompLink Cluster (6 groups)			Selected/ Alternate Ranges
		Range	Mean	Median		Range	Mean	Median	Range	Mean	Median	
Low	16	11.0-25.0	21.2	18.0	11.0-25.0	11.0-28.0	21.2	18.0	11.0-25.0	21.2	20.5	18.0-23.0
									28.0-37.0	32.6	34.0	
Medium	47	28.0-45.0	36.7	36.0	28.0-40.0	28.0-39.0	33.6	33.5	34.0-43.0	39.1	38.5	33.0-36.0
									42.0-47.0	49.1	48.0	
High	32	46.0-61.0	48.9	53.5	41.0-61.0	39.0-61.0	46.5	50.0	46.0-55.0	45.6	46.5	46.0-61.0
									56.0-61.0	58.5	58.5	

Table 3.5.
Selected Case Study Characteristics

Hospital Site	Category	Rural/ Urban	Hospital Size (# beds)	Faith-based	Health System Component	Staff-led	LHD Collaboration	Total Score
1	Low score, Nonmetro	5	93	NO	NO	YES	NO	**18**
2	Low score, Metro	1	112	YES	YES	YES	NO	**21**
3	Medium score, Nonmetro	6	25	NO	NO	NO	NO	**35**
4	Medium score, Metro	1	235	YES	YES	YES	NO	**35**
5	High Score, Nonmetro	4	124	NO	NO	NO	YES	**56**
6	High Score, Metro	1	101	NO	YES	YES	YES	**55**

community stakeholders' involvement in decision-making. Based on the phase I review of the reports, we identified eleven potential decision-making opportunities throughout the process. These decision-making opportunities were 1) development or selection of initial assessment and planning model or approach; 2) community stakeholder and community member involvement (who involved and how); 3) data collection (methods and involvement); 4) data analyses (methods and involvement); 5) data interpretation; 6) identification of health needs; 7) prioritization of health needs; 8) identification of other stakeholder who should be involved based on priorities; 9) identification of resources; 10) identification of strategies to address health needs; and 11) implementation of strategies to address health needs.

For the vast majority, senior leadership teams within health care systems and/or hospitals were the primary decision-makers throughout the processes. In larger health care systems, decisions in the assessment process, such as community health needs identification and prioritization, were typically made for all hospitals at the health care system-level. Decisions related to planning process, including strategy selection and implementation of strategies, were made at the hospital-level. Often, hospitals were not even aware of the assessment and planning requirements. According to one hospital-level key informant, "*[health care system key informant] approached us…gave us our community needs assessment and [said] we needed to come up with our implementation strategy. That was the first time I'd heard really about the IRS and that we needed to do this report…*" Stand-alone hospitals were similar; it was usually the senior leadership teams who made decisions. A consultant, who worked with a small stand-alone facility,

indicated all decisions were made by "*their administrative team: their CEO, CNO, and CFO…*". The key informant for this site said, "*it was really senior management…[site 3 consultant] just did her phone interviews and gathered the information that she needed from them. Then, we had a few calls along the way where they [consultants] were just updating us on the information they had."*

Of the ninety-five CHNA/implementation strategies reports we reviewed in phase I, only three reports involved community stakeholders and community members in decision-making steps throughout most of the process. However, these hospitals involved a wide variety of stakeholders in decision-making at almost every step of the process. According to the site most closely resembling "stakeholder/community control," early in the process "*about 50 of our top leaders across the community*" were polled and asked "*what do you think…are the biggest unmet health needs? What do you know about your community? What do you think your demographics are*?" The next major step with decision-making activities was at a community health summit attended by 100 community stakeholders and community members. After the data presentation and group discussion, each attendee voted on the top three community issues with sticky notes to prioritize health needs. After that, "*each table takes on one of those topics and is responsible [for] coming up with three goals for that topic area...three tactics for each of the three goals…to further define who should have responsibility and also come up with specific measurable goals.*" According a site five key informant, these health topic-specific work groups have continued to meet to address the issues.

Another hospital with broad-based decision-making throughout the process said, *"we did a lot of work at the grassroots level in terms of where the information came from….[we] did a [health issue] prioritization exercise for the community through Survey Monkey. I think we had 780 responses that were really nicely distributed throughout the areas of the community."* The process *"really took us a year. Obviously, that's working through all the working groups, and the community groups, and everybody going back and rewriting and approving. There were no rubber stamps. People really had to engage, which takes longer."* Clearly, there were examples of community stakeholders providing input, and informing and making decisions throughout the assessment and planning processes. A larger proportion of hospitals might follow suit if the final IRS regulations are more explicit about roles of public health experts, community members, and representatives for medically underserved, low-income, and minority populations.

Selection for participation. Selection for participation is categorized in two groups: anyone with a stake in the program or process (also referred to as all legitimate groups) and primary users who have a vital interest in the process (Cousins, Donohue, and Bloom, 1996; Cousins & Whitmore, 1998). Again, the draft regulations identify participation by those with special knowledge of or expertise in public health; health departments or health agencies; and "leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility" (IRS, 2013, April 5).

We interpret this as more expansive than primary users, but not as inclusive as all legitimate groups.

If any one legitimate group is excluded, intentionally or not, participation cannot be categorized as anyone with a stake in the program or process. However, it is unlikely the IRS-required groups would be considered primary users. Consequently, for the purpose of the assessment and planning process, we categorized the selection for participation, in seven groups, along a continuum: consultants; health-system leadership; hospital leadership; health system and/or hospital boards; health-related stakeholders; broader community stakeholders, selected to represent community members; and community members. Using the participatory evaluation framework, consultants could be likened to external evaluators who, at a minimum, conceptualize the assessment and planning approach, facilitate the process, and gather, analyze, interpret, and report the data. While this role would likely differ by consultant and hospital, there is potential for them to play a significant role with considerable influence over the process. Thus, they are listed first on the continuum.

Most hospitals involved broader community stakeholders, including representatives of local health centers, health departments, chambers of commerce, public education, local government, and local elected officials to gain input on community health needs through interviews, surveys, and/or focus groups. Community members occasionally participated as well, although their involvement was limited to providing perspectives on community health issues through surveys. Other hospitals and health care systems only engaged their board members. One hospital acknowledged the

importance of community participation in their CHNA/implementation strategies report by saying, "*creating healthy communities requires a high level of mutual understanding and collaboration with community individuals and partner groups."* However, according to this system-level key informant for this site, "*In our system, each hospital has it's own board made of community members. Their entire board is made up of people from their service area*." These board members were those who represented the broad interests of the community and provided input. The same was true at small, stand-alone hospitals.

Our concern for participant selection is not only *who* was identified and involved but *how* they were identified. Primarily, hospitals relied on existing partnerships for participant selection. When identifying community stakeholders to gather input, "*we started, actually, with our community partners, which are basically healthcare providers to the underserved community. Those were the first people we knew for a fact we were gonna reach out to because they're the ones who are, effectively, on the ground level, working, specifically, every single day with the underserved community*."

One consultant, who took a collaborative approach to the process, provided the hospital with "*a list of everybody we'd like for them to invite. A lot of times—some of these hospitals don't think about the schools, the churches. Some of the other people that are actually filling in the gaps of health care in their community. That's why we say, 'Here are the people we'd like to have at the summit. Please invite all of these folks and get the word out.' We're trying to push that out to the rest of the community, so that the whole community has a stake in improving health status.*" Should the final IRS regulations specify broader community stakeholder groups, beyond those currently

required, and mandate hospitals to engage them throughout the process, there would be opportunities to pool, leverage, and mobilize resources; garner support to address issues beyond hospitals' expertise and capabilities; identify and address issues using a broader, ecological approach; and build community capacity. Further, this benefits hospitals by dispersing the work among multiple organizations and agencies and increases likelihood of improving population health. As the site five consultant said, "*I don't know how you do this without engaging the community fully in this process. I just think it would be overwhelming to try to do this without the community's help*."

Depth of participation. Depth of participation is also viewed along a continuum: no participation/consultation-only; moderate participation; and extensive participation (Cousins, Donohue, and Bloom, 1996). Again, the IRS guidance does not specify the extent of participation beyond taking into account input, which we interpreted as consultation-only. We categorized the community participation activities in Table 3.2 using the depth of participation framework:

- No participation/consultation-only – No attempt to engage community stakeholders or members; engagement of health-related stakeholders, broader community stakeholders, and/or community members to identify health needs through surveys, interviews, and/or focus groups; verified or validated health needs/priorities with local experts
- Moderate participation – Involvement of community stakeholders in priority identification; involvement of community stakeholders in strategy selection

- Extensive participation – Involvement of community stakeholders and community members to develop and carryout strategies

No attempts to engage community stakeholders or community members occurred in about eighteen percent of CHNA reports (n=17), and most frequent occurred when existing assessment documents were used to supplant any primary data collection methods. The depth of participation for the majority of CHNA processes was consultation-only. Eighty percent (n=76) of the assessment and planning processes engaged broader community stakeholders, as representatives of community members, in surveys, interviews, and/or focus groups to identify health needs. A site system-level key informant said:

> *"We interviewed a lot of health community leaders, to get their feedback and input on what they thought was a priority in their community, or, specifically, what they saw in their own patient base. We even got a quote from City Mayor on what her views are because, again, you want your report to have some kind of credibility. I mean, anybody can slap some stats in a report and say, 'Hey, yeah, we found this here,' but it really did help add credibility to be able to add actual quote from these health leaders and governmental leaders that say, 'Yeah, we agree. This is a need.'"*

More than one-quarter of the CHNA processes involved community members in surveys, interviews, and/or focus groups to gain perspectives on health needs (28

percent; n=27). One consultant-led process discussed their approach: "*we [consultants] actually go meet with the mayor and the sheriff and the head of the United Way and any other big foundation and sit down with them for about a 30-minute interview and really hone in on what they are hearing in their constituencies and what they believe to be the major health issue.*" The first step was "*to poll about 50 of our top leaders across the community.*" The consulting firm then did 300 to 400 surveys with community members.

Even those hospitals with broad-based participation to identify health needs during the assessment and data collection phase, very few engaged stakeholders in prioritizing community health issues or selecting strategies to address issues. Only four percent (n=4) of the Assessment and planning processes went beyond consultation to moderately or extensively involved community stakeholders. Only two percent (n=2) hospitals of ninety-five, including one of the six cases, had extensive participation at multiple steps of the assessment and planning processes.

At a case study site with extensive community involvement, once all data were collected and analyzed, the consultants presented the findings at a community-wide summit with 100 attendees. "*The first part of the summit was primarily hearing all of the information that they [the consultant] learned and sharing the report…The second part was roundtable discussions…to spend the next three hours thoroughly discussing*" the issues. "*The consultants then listed about 20 areas*" based on the discussion and each attendee was given three sticky notes to vote. "*Depending on where the majority of sticky notes were, those were the ones we decided or committed to tackle that first three years.* With six areas identified, the summit attendees broke into groups and each group

identified three goals, three strategies, and *"organizations within the community that would be accountable to helping us stay on track for the next three years to do something about each of these areas. Then there were people and organizations that volunteered to partner with us in helping us make headway over the next three years changing that need*."

Discussion

While carrying out the draft regulations for the health assessment and planning processes, there was wide variation in community participation. There were differences in community participation in terms of the types of stakeholders involved, the extent of their involvement, and the types of activities in which they participated. Given these variations, unless the final IRS regulations provides specific guidance for these processes and reports, the majority of hospitals are likely to meet the minimum requirements for stakeholder involvement. Even hospitals that acknowledged the importance of community participation in their CHNA/implementation reports did not always reflect this in their processes.

Revisiting the earlier definition of community participation, generally, involvement was neither active nor diverse. While seemingly critical of hospitals, we acknowledge the constraints on them to complete and meet these requirements. Hospitals faced time and personnel constraints and ever-changing requirements that have yet to be finalized. Nonprofit hospitals are expected to provide community benefit; however, this is typically interpreted as charity care for underserved populations. This is not surprising given that CHNA/implementation strategies reports largely adhered to the

medical model (Pennel, McLeroy, Burdine, & Matarrita-Castante, 2014). Most hospital staff do not have the training or expertise to engage and mobilize community members in health assessment and planning processes.

Given that hospital CHNA/implementation strategies reports varied considerably in quality and approach, even beyond community participation, we recommend the final IRS regulations provide more detailed guidance (Pennel, McLeroy, Burdine, & Matarrita-Castante, 2014). Not all stakeholders would choose to be involved, and not all involved stakeholders would chose to be involved extensively and at every stage. However, hospitals should be required to make concerted efforts to include community stakeholders and community members throughout the assessment and planning processes. The final regulations should include a broader list of suggested community stakeholder-types to be invited to participate in a meaningful way throughout the process. While this might be difficult to regulate, the current IRS reporting requirements for these processes only require a "yes/no" checkbox on the Schedule H reporting form. Additional checkboxes could easily be added.

There are various community health assessment, organization, and planning models the IRS could mandate hospitals use, all of which comprise some form of community participation. These include Planned Approach to Community Health (PATCH), Mobilizing For Action Through Planning And Partnerships (MAPP), Community Health Improvement Process (CHIP), and the community health development model (Burdine, Felix, & Wendel M, 2007; Burdine, McLeroy, Blakely, Wendel & Felix, 2010; Felix, Burdine, Wendel, & Alaniz, 2010; IOM, 1997; NACCHO,

2013; U.S. Department of Health and Human Services, n.d.). Beyond the numerous benefits we mentioned previously, using such models could begin identifying and addressing underlying social determinants of health, build capacity for future collaborations and problem-solving, and increase the likelihood of improving population health status. This also provides a broader model that allows hospitals to align community health assessment and planning processes with other organizations and agencies.

In 1994, Freudenberg, Eng, Flay, Parcel, Rogers and Wallerstein proposed a research agenda to strengthen individual and community capacity to prevent disease and promote health. At the time, the main reasons were based on trends that had changed public health practice. These included blurred distinctions between chronic, infectious and "social" diseases; a continued growth of health disparities between the rich and poor; increasing diversity of the U.S.; and a healthcare system that was undergoing change (Freudenberg, Eng, Flay, Parcel , Rogers & Wallerstein, 1994). All of these reasons still apply, if not more, today.

Limitations and Delimitations

The choice of methodology and methods for this study involved both limitations and delimitations. Procedures were incorporated to address credibility, dependability, and confirmability issues. This cross-sectional, retrospective study only provides a snapshot at a single point in time. Due to the IRS timeline requirements, the first cycle of health assessment and planning processes were completed prior to the commencement of this study. We were not able to directly observe the processes and interactions.

Therefore, we were reliant on reconstructed perspectives represented by the key informants, consultants, and community stakeholders interviewed, which are subject to recall bias. Further, our viewpoint, particularly as it related to community participation, imposed our perspective on the methodology, the research question, and data collection, analysis, and interpretation.

The parameters we set for this study limited us to nonprofit hospitals in Texas. The review and evaluation of the CHNA/implementation strategies reports included fifty-three percent of the nonprofit hospital population. We selected six cases we thought represented a wide range of contrasting cases and corroborated our selection with confirmatory cluster analysis. Within each case, we were limited by our ability to reach participants who were involved the assessment and planning processes and report development. Given the lack of community engagement, we did not interview as many community stakeholders as we had anticipated. The participatory evaluation framework created study parameters, but this limited our frame for analyzing and interpreting the data. Finally, as an unfunded dissertation study, we were limited by time, research team staff, and funding. Thus, phase I and phase II data collection and analyses were time limited, which affected the depth of reporting. Many interviews were conducted by telephone, as travel to most locations was not practicable. This would have enhanced our understanding of the processes as well as internal and external contextual factors. Lastly, we lacked sufficient time and personnel to adequately assess inter-coder reliability.

CHAPTER IV

POLICY INTENT, INTERPRETATION AND IMPLEMENTATION: RECOMMENDATIONS FOR COMMUNITY HEALTH NEEDS ASSESSMENT REGULATIONS

Introduction

Nonprofit hospitals, like other nonprofit organizations, are tax exempt, but must demonstrate community benefit to the IRS to maintain this status. According to the Patient Protection and Affordable Care Act of 2010 (ACA), nonprofit hospitals must also conduct a community health needs assessment (CHNA) at least every three years and implement strategies to address identified priority needs (IRS, 2013, April 5). While final regulations have not been issued, the Internal Revenue Service (IRS), the bureau responsible for the regulation and enforcement of Section 9007 of the ACA, provided draft regulations to guide nonprofit hospitals through the first three-year cycle.

Due to the lack of ACA legislative history and absence of final IRS regulations, the explicit purpose of the CHNA/implementation strategies legislation and IRS regulations are unclear. It is not evident whether the intent of the policy is to improve documentation and reporting of community benefits by nonprofit hospitals or to compel hospitals to improve efforts to address community health needs. We think addressing community health is critical to improving population health, but, as it stands now, hospitals will likely continue to perform “business as usual.”

The purpose of this article was to examine interpretations and the implementation

of the draft regulations by nonprofit hospitals in Texas. We reviewed nonprofit hospital CHNA/implementation strategies reports and conducted interviews with key informants, consultants, and community stakeholders. Before reporting on the hospital reports and interviews, the reader may find it useful to briefly review the history of charity care and community benefits provided by nonprofit hospitals and the continued concerns that led to the CHNA requirements. We will end with a discussion and recommendations for nonprofit hospitals and the final IRS regulations.

Background

History of Nonprofit Hospitals and Community Benefits

In 1956, the IRS determined a hospital could qualify as a tax-exempt charitable organization and issued Revenue Ruling 56-185 (Hanson, 2005; Internal Revenue Service [IRS], 1956; Joint Committee on Taxation, 2006, September 12). Under this ruling, nonprofit hospitals were required to provide charity care for the poor, based on their financial ability to do so, in exchange for nonprofit status. They also had to satisfy five qualifications applicable to all nonprofit organizations. To qualify as a 501(c)3, organizations 1) must be organized exclusively for charitable purposes, 2) must be operated exclusively for charitable purposes, 3) must ensure private shareholder or individual do not benefit from net earnings, (4) may not engage in substantial legislative lobbying and (5) may not participate or intervene in a political campaign (Internal Revenue Service [IRS], 1969; Joint Committee on Taxation, 2006, September 12).

With the advent of Medicaid and Medicare, employer supplied health insurance, and third party payers, nonprofit hospitals were not providing the same level of charity

care they had in the past (Joint Committee on Taxation, 2006, September 12). Thus, in 1969, the Internal Revenue Service (IRS) established Revenue Ruling 69-545, the community benefit standard for nonprofit hospitals. To maintain the nonprofit status hospitals must:

1. operate a full-time emergency room (ER) open to all patients, regardless of ability to pay, with some exceptions;
2. accept patients able to pay for care, either directly or through third party reimbursement;
3. be governed by a board of independent community members;
4. make medical staff privileges available to all qualified physicians in the area; and
5. use excess funds to improve the quality of patient care, expand facilities, and advance training, education, and research programs.

(IRS, 1969; Sherlock & Gravelle, 2009).

The 1969 revenue ruling allowed a broader definition of community benefit as well as widespread interpretation of its meaning. This lack of definition and guidance led to ambiguity (Bazzoli, Clement, & Hsieh, 2010). Minus the emergency provision, this is largely the community benefit that exists today.

Community Benefit Concerns

In the 1990s, concerns began to surface about whether the benefits nonprofit hospitals provided communities were sufficient to justify their tax-exempt status. Nonprofit hospitals are not only exempt from federal taxes, but they are also eligible for state, local property, and sales tax exemption as well as tax-deductible charitable

donations (GAO, 2008). In 2006, it was estimated the overall value of federal, state, and local tax exemptions for nonprofit hospitals was $12.6 billion (Congressional Budget Office, 2006). However, studies show there is little difference between community benefit provided by nonprofit and for-profit hospitals. The Congressional Budget Office found the average level of uncompensated care, one of the main standards of community benefit, as a share of the hospitals' operating expenses was highest for government hospitals (13%). The share for nonprofit and for-profit hospitals was fairly similar at 4.7 percent and 4.2 percent, respectively (2006). Others have suggested the community benefit nonprofit hospitals provide is much less than the tax exemption benefits the hospitals receive (Congressional Budget Office, 2006; GAO, 1990; GAO, 2005; Nicholson, Pauly, Burns, Baumritter, & Asch, 2000; Schlesinger, Mitchell, & Gray, 2003). However, there is a wide range of community benefit expenditures among nonprofit hospitals, with urban-based teaching hospitals taking a significant disproportionate share (Congressional Budget Office, 2006; GAO, 1990).

Type of benefits. Another concern is the type of community benefit nonprofit hospitals provide. A recent national study examined the benefit nonprofit hospitals provided to communities in the United States (Young, Chou, Alexander, Lee, & Raver, 2013). While contributions varied, overall the study found nonprofit hospitals applied 7.5 percent of their operating expenses to community benefit. Of this 7.5 percent, the vast majority (6.4%) went to direct patient care: 1.9 percent went to charity care, 3.4 percent went to unreimbursed costs for means-tested government programs, and 1.1 percent to subsidized health services. Other community benefits included community

health improvement (0.4%), cash or in-kind contributions to community groups (0.2), research (0.1), and health-professions education (0.4%) (Young, Chou, Alexander, Lee, & Raver, 2013). More than forty-five percent of community benefit exeditures went to offset unreimbursesd costs for means-tested government programs, primarily Medicaid losses. This categorical breakdown was almost identical to a study conducted with Wisconsin nonprofit hospitals (Bakken & Kindig, 2012). These are troublesome findings given the debate about including unreimbursed costs for means-tested government program as community benefit.

Lawsuits

Between 2004-2005, over forty-five lawsuits were filed against nonprofit hospitals in twenty-five states that challenged the level of charity care being provided as well as the treatment and billing of low-income and uninsured patients (Hanson, 2005; Helvin, 2013; Joint Committee on Taxation, 2006, September 12). However, the lack of clarity in the community benefits regulations did not provide the support necessary for any of these cases to move forward (Hanson, 2005; Helvin, 2013). While these cases were dismissed, they brought attention to the issue and began raising more concerns.

IRS Reporting

Much of the accountability and transparency issues have to do with how community benefits are reported. There is little to no reporting oversight and insufficient uniformity in reporting (Helvin, 2013). Until 2009, nonprofit hospitals completed the same IRS form, Form 990, as all other nonprofit organizations. Due to increased

attention and criticism, the Schedule H was developed in 2007 specifically for nonprofit hospital reporting. Reporting of all Schedule H sections began with the 2009 tax year.

Part I of schedule H "requests details about a hospital' s charity care program and attempts to quantify charity care expenditures" (Lunder & Liu, 2008, p. CRS-7). This includes charity care; unreimbursed costs for means-tested government programs (e.g., Medicaid shortfalls); subsidized health services; community health improvement services and community-benefit operations; research; health-professions education; and financial and in-kind contributions to community groups. Part II, community building activities, includes physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, and workforce development. Despite opposition, the Catholic Health Association strongly advocated for the inclusion of Part II, arguing the importance of social and environmental determinants of health (Lunder & Liu, 2008). It is still unclear the stock the IRS places in Part II. Part III quantifies the costs due to Medicare shortfalls and bad debts owed to the organization. Parts IV, V, and VI request information about joint ventures, facility information, and supplemental information. The purpose of the Schedule H was "to combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care." (Internal Revenue Service, 2007, June 14). However, there are no minimum community benefit standards.

More recent updates to the Schedule H are based on provisions in the Patient Protection and Affordable Care Act of 2010 (ACA). These include development of

policies for charity care financial assistance, emergency medical care, and billing and collections for those charity care-eligible patients. It also includes reporting on the required community health needs assessment reports and implementation strategies (Internal Revenue Service [IRS], 2014, March 4). Other than lack of reporting oversight, one of the primary problems with reporting, particularly for the assessment and planning processes is that questions are asked in a yes/no format, which says nothing about the quality of the processes and reports.

Methods

Research Design

We used an embedded, mixed methods case study methodology to examine and better understand interpretations and implementation of the draft regulations by nonprofit hospitals in Texas. In phase I, we reviewed ninety-five implementation strategies reports to ascertain whether the IRS draft regulations altered hospitals' approaches to community benefits. In phase II, we interviewed key informants, consultants, and community stakeholders involved in implementation of the draft regulations to understand interpretations and approaches to implementation. An overview of phase I quantitative methods and phase II qualitative methods are provided below. More detailed methods can be found in Pennel, McLeroy, Burdine, and Matarrita-Castante, 2014 and Pennel, McLeroy, Burdine, Matarrita, & Wang, 2014, which can be obtained from the lead author. We received approval for this study from the Texas A&M University Office of Research Compliance Human Subjects Protection Program.

Phase I: Quantitative Methods

Data collection and analysis. We accessed publicly available implementation strategies reports through web-based searches. We reviewed ninety-five implementation strategies reports to ascertain whether the draft regulations changed hospitals' approaches to community benefits. Reports were classified into three categories: intent to implement strategies outside the typical scope of hospital community benefit operations, intent to continue normal operations, and uncertain, when intent was not clear. While this was sometimes difficult to interpret, indications of intent to implement strategies outside the normal scope included verb tense (e.g., "We will offer classes…" versus "We offer classes…") as well as action verbs (e.g., "create, develop, or establish a program" versus "continue a program").

Case selection. Using purposive sampling, we selected six cases of the ninety-five CHNA/ implementation strategy reports reviewed in Phase I. We conducted confirmatory cluster analysis using key selection criteria to verify the range of contrasting cases selected using purposive sampling. We conducted hierarchical cluster analysis using complete linkage, which measures the maximum distance between observations in two clusters, and k-means. Case selection methods are described in more detail in Pennel, McLeroy, Burdine, Matarrita, & Wang, 2014.

Phase II: Qualitative Methods

Participants. Sixteen interviews were conducted with nine key informants, three system-level and six hospital-level; three consultants; and four community stakeholders. Key informants and consultants were identified using the CHNA/implantation strategies reports. Key informant and consultant interviews lasted forty to sixty minutes. We used snowball sampling by asking key informants and consultants for referrals to external partners involved in the assessment and planning processes. When names were provided, we contacted external partners and requested an interview. We also contacted community stakeholders referenced in CHNA/implementation strategies reports or stakeholders we would expect to be involved, particularly for sites that did not identify community stakeholders. We completed interviews with four community stakeholders. Community stakeholder interviews ranged from twenty to forty minutes. An additional three community stakeholders did not think they had much to contribute due to their lack of involvement in the Assessment and planning process. While they were not interviewed, they received study information and informed consent and waived documentation of consent. Participant information is described in more detail in Pennel, McLeroy, Burdine, Matarrita, & Wang, 2014.

Data collection and analysis. We conducted semi-structured interviews with key informants, consultant, and community stakeholders during March-May 2014, using an interview guide with open-ended interview questions and a flexible interviewing technique. When permission was granted, interviews were audio recorded using an Olympus digital voice recorder. All interviewees consented to audio recordings. Audio

recordings were transcribed by a professional transcription service. Upon receipt of transcripts, they were reviewed for accuracy and de-identified.

We created a database to organize and document sources, data, and interpretations of the data using QRS NVivo 10. For the purpose of this article, we reviewed the content of the six CHNA/implementation strategies reports to inform hospitals' interpretation of the draft regulations and approach based on interpretations. Data sources imported into the program included the de-identified interview transcripts, site memos, CHNA/implementation strategy reports, case summaries, and other relevant documents, emails or notes. We used interviewee and potential interviewee rationale and tracking procedures in Microsoft Excel and decision logs in Microsoft Word to document processes, interpretations, and decisions between and within phase I and phase II.

We used the constant comparative analysis method – an iterative process that involved concurrent data collection and analysis, followed by preliminary coding of data, categorizing based on codes, and developing preliminary broad themes or concepts. We qualitatively coded and developed initial categories for themes and items related to interpretation, purpose, and approach using interview transcripts and CHNA/implementation strategies reports. We coded data using QRS NVivo 10 qualitative software. We used naturalistic generalization in cross-case analysis to identify similarities and differences in case study details based on our experiences and reflections on the details and descriptions presented in the case profiles (Stake, 1995).

More detailed data collection and analysis methods are described in more detail in Pennel, McLeroy, Burdine, Matarrita, & Wang, 2014.

Results

We found a wide-range of interpretations and approaches based on the CHNA/implementation strategies reports and interviews with key informants, consultants, and community stakeholders.

Phase I: Quantitative Results

Change in approach to community benefits. Of the ninety-five implementation strategies reports reviewed, the vast majority of hospitals (n=67; 70.5 percent) appeared to approach community benefits operations as they had in the past. Strategies they identified to address health priorities included continuation of existing programs and activities and implementation of pre-planned medical activities (e.g., continue screenings at health fairs, continue recruiting physicians, continue providing applications to government programs, implement specialist telemedicine program, and provide an integrated delivery system for underserved patients). Only nine reports (9.5 percent) suggested hospitals' intent to implement strategies outside their normal scope of activities. Examples of new strategies included establishing partnerships with businesses, schools, and ministerial alliances to address general wellness, asthma, and other health priorities, initiating a farmer's market in an identified food desert where healthy foods could be made available at low-cost, to collaborate and "act as a connector to engage and work with local taskforces and committees addressing child and maternal health" in the area, and to "be a voice for children locally and state-wide, especially around the major

issue areas identified in this needs assessment" and "help ensure sound policy is developed around coordination and integration of care." For the nineteen remaining implementation strategy reports (20 percent), we were not able to determine if hospitals were diverging from past community benefits approaches. Table 4.1 summarizes approaches to community benefits based on review of implementation strategies reports.

Table 4.1.
Nonprofit Hospitals' Change in Community Benefits Approach

Community Benefits Approach-type	Frequency n=95	Percentage
Approach congruent with normal operations	67	70.5%
Approach varies from normal operations	9	9.5%
Uncertain of approach	19	20%

Phase II: Qualitative Results

Documented purpose. The purpose is as wide ranging as the quality, which is evident even in the stated purpose within CHNA/implementation strategies reports. One case study site that appeared to emphasize compliance stated the purpose as, *"to identify the health needs of the communities served by [case study site] and meet the requirements for community benefit planning as set forth in state and federal laws, including, but not limited to, Texas Health and Safety Code Chapter 311 and Internal Revenue Code Section 501(r)."* Another case study site's report displayed a broader perspective, with a stated purpose of *"[creating] opportunities for health improvement, [creating] a collaborative community environment to engage multiple change agents,*

and [opening] a transparent process to listen and truly understand the health needs of [case study site County], Texas." Despite this broader purpose, sites like this were rare. If the intent of policy makers and government officials is for nonprofit hospitals to move beyond improved documentation and reporting, the finalized IRS regulations will need to provide a clear purpose and more direct guidance.

Transparency and documentation. Due to the ramifications of noncompliance, hospitals' primary goal was to meet the minimum assessment and planning requirements. Based on the interviews and review of CHNA/implementation strategies reports, the purpose that emerged was overwhelmingly compliance with the IRS draft regulation. The interpretation of intent for many hospitals was simply improving community benefit documentation and reporting. According to one consultant, who worked with hospitals throughout the United States, "*we really feel like not-for-profit hospitals…are doing a good job meeting the community needs, and so a lot of this is documentation*." This consultant went on to say, they (the health care management firm) believe hospitals are providing sufficient community benefit simply by keeping "*assets within a community, as opposed to having them go to an investor-owned company. Just the economic benefit of having those hospitals within the community is significant."* When asked what this process might change, a hospital-level key informant said, "*the only thing that might change is better record keeping of what we are doing…just to make sure we're capturing the things that we're doing. That's the main thing. We do a lot of services. I don't think we needed to add anything. I just think we need to make sure we're capturing it all."*

Alignment. Hospitals also sought to align the assessment and planning processes with other hospital initiatives, particularly Delivery System Reform Incentive Payment (DSRIP) and marketing plans: *"Let's just be more strategic about what you are doing, as opposed to, let's go do a whole bunch of new stuff…You've got your marketing plan going. You've got this implementation [strategies] plan. You've got your DSRIP projects. They all really need to come together so the hospital can really focus on what they need to do."* Another hospital with DSRIP projects said, "*we do participate in waiver 1115, so we're trying to make sure that what we were doing would also benefit for additional projects."* Further, they were trying to align federal reporting with state reporting: *"In Texas, we have to report on community benefit, and that's something that we do every year. We have wrapped those activities in with this. There's different reporting that the hospitals have to do, but it's still based on this overlap."* While such alignment could avoid duplication and result in more appropriate use of resources, the purpose of these assessments and plans are different and not concerned about community benefit. DSRIP and 1115 Waiver projects and strategies are predominately associated with direct patient care as opposed to the health of the community, and nonprofit hospital marketing plans begin to look more and more like for-profit hospital marketing plans.

Enhanced community benefits. Other interviewees thought the processes were not solely about improving documentation and reporting, but doing more to meet expectations of the government and the community. A hospital-level key informant shared her thoughts on the purpose: "*the whole, overall process of nonprofit*

organization and how we justify that status by…valuating services we provide for free. We're having a business without paying the taxes, so we need to be able to justify, explain what services we are providing equivalent to what we would've been paying in taxes." A consultant also thought the IRS requirements were asking more of nonprofit hospitals to rightfully justify their tax-exempt status: "*I believe what they're [IRS] trying to say is 'if we are going to tax exempt you, hospital, then you've got to be able to provide us with the documentation and rationale for what that is.' It's really important because…the amount of taxes that all of the community nonprofit hospitals would have to pay in the United States if they weren't tax-exempt is astronomical*."

Population health status improvements. Despite recent movements toward population health improvement through various national initiatives, very few hospitals thought this was about shifting hospitals' focus toward improving population health. This is reflected in the quantitative results as well as findings from interviewees. One system-level key informant indicated the community benefits staff and system-level leadership were shifting their perspective toward health status improvement of the community. Although a struggle, she began noticing a difference in the way health system staff, particularly non-clinical staff, were thinking and placing a greater emphasis on population health: "*[this] is new for [our] health care system. That's been difficult for me and for a lot of my team to be able to say, 'no, it's not just about treating them.'*" According to one consultant, "*this is a very high risk if it's not taken seriously for a hospital…hospitals have been doing, I think, a really good job in looking at overall community benefit. The needs assessment…this was probably one of the few areas that I*

think the IRS has some genius behind it to say, 'what we're gonna do is try to incentivize hospitals to really improve the health status as opposed to just delivering care.' That's their main intent with this legislation." Another consultant agreed*: "It would not surprise me in the least bit if the [Form] 990 starts asking questions like, 'Have you improved the health of the community by your implementation strategy,, and how?'"* However, she was doubtful this would bring about changes in population health status: "*I don't think that because we've had to go through this process, the hospitals are going to influence the health of the community any more than they already were doing*."

Discussion

"Policy formulation and implementation are interdependent activities;" however, policies are not always implemented as intended (Hunter & Killoran, 2004,p. 7). Following the trail from intent to interpretation to implementation is particularly difficult when there is no legislative history and regulations are still in draft form. Based on research, it is largely agreed the purpose of the policy is to ensure nonprofit hospitals are providing sufficient benefit to communities to justify their tax-exempt status. In her paper, "Principle to Consider for Implementation of a Community Health Needs Assessment Process," Rosenbaum provided seven recommendations with which we agree (2013). Our recommendations build on these, and are intended to provide guidance to hospitals, as they begin the second three-year assessment cycle, as well as for the final IRS regulations.

We suggest the following:

1. Define the clear purpose and intent of final IRS regulations

   The intent of the legislation and proposed rule are currently unclear. Intent could be interpreted as and include:

   - improved transparency, documentation, and reporting;
   - expectations that nonprofit hospitals provide stronger evidence to justify their tax-exempt status;
   - increased provision of charity care;
   - begin shifting hospitals' focus toward prevention, health promotion, wellness, and population health improvement, or
   - all of the above.

   The ambiguity of past community benefits regulations has contributed to the wide variation in how nonprofit hospitals provide community benefit and weakened the ability of the community to gain benefit through the legal system. This intent and purpose of the CHNA process and report should be clearly stated to ensure more common interpretation and implementation. We recommend the final regulations move beyond hospital accountability and require nonprofit hospitals begin focusing on community health issues and strategies to improve population health status.

2. Engagement of community stakeholders and community members

   Others have stated the numerous benefits of engaging community stakeholders and community members in community health assessment, organization, and planning processes (Bess, Prilleltensky, Perkins, & Collins, 2009; Eng, Hatch, & Callan,

1985; Granner & Sharpe, 2004; Israel, Schulz, Parker, Becker, 1998; Israel, Schulz, Parker, Becker, Allen, Guzman, 2008; Leung, Yen & Minkler, 2004; Minkler, 2005; Roussos & Fawcett, 2000; Shortell et al., 2002; Spatig, Swedberg, Legrown & Flaherty, 2010; Wallerstein, 1999). Given the ineffectiveness of lawsuits against nonprofit hospitals, Hanson called for grassroots community organizing: "in return for their valuable tax exemptions and related perks, nonprofit hospitals are expected to provide health benefits to the *local communities* in which they operate. So communities already have the right-perhaps even the responsibility-to actively participate in the planning and implementation of their local nonprofit hospitals' community health benefit programs…too many communities have done little or nothing to exercise this right, and too many nonprofit hospitals are quite happy to leave community members out of the process" (Hanson, 2005, p. 405). The final regulations should include requirements that hospitals make concerted efforts to include community stakeholders and community members throughout the assessment and planning processes. The final IRS guidance should entail the engagement of community stakeholders beyond categories currently required – those with public health expertise and representatives of low-income, underserved, and minority populations. A list of additional stakeholder-types might include representatives of public, private, and higher education, law enforcement officials, business owners, community and faith-based organizations, governmental officials, policy makers, other health care-related entities, neighborhood organizations, and private residents. The final regulations should include invitations to participate as

well as meaningful ways for communities to contribute throughout the process.

3. Identification of root causes and social and environmental determinants of health

   Many factors contribute to health. According to Healthy People 2020, the five key determinants of health are economic stability, education, social and community context, health and health care, and neighborhood and built environment (U.S. Department of Health and Human Services, 2014, May 24). Research strongly suggests clinical measures, such as quality of and access to health care, contribute little to overall health compared to other factors. One model, used in U.S. county health rankings, attributes twenty percent of health to clinical care. The remaining factors social and economic factors, health behavior, physical environment contribute 40 percent, 30 percent, and 10 percent, respectively (University of Wisconsin Population Health Institute, 2014). McKinlay and McKinlay credited clinical measures with no more than 3.5 percent of the decline in mortality since 1900 (1986). Throughout time, others have successfully argued that health and illness are largely influenced by social and economic factors (Doyal, 1979; McKeown, 1976). Recommendation #2 will provide a broader perspective and resources that can be leveraged to identify and address social and environmental determinants of health. The final IRS regulations should require, with the assistance of these broad stakeholder groups, the exploration of root causes of health issues, and identification of broader determinants of health.

4. Emphasize population health improvement

   This provides an opportunity to build on other national policies and initiatives to improve population health, including the Institute for Healthcare Improvement triple aim, primary care and public health integration, Accountable Care Organizations, the Prevention and Public Health Fund, and new community benefit requirements for nonprofit hospitals (Berg, 2009; Hacker & Walker, 2013; Nobles & Casolino, 2013). Hospitals, particularly clinicians, have a tendency to view health as the treatment of ill patients. Taking a disease prevention and health promotion approach to the CHNA/implementation strategies can align this IRS requirement with other initiatives. For population health improvements to occur, following recommendations #2 and #3 will aid the 1) identification of root causes of health issues, 2) adoption of clinical *and* non-clinical strategies to address health priorities, and 3) identification of clinical *and* non-clinical community resources. A key and often-effective non-clinical strategy is policy development. Hospitals and its leadership are often viewed as trusted community leaders with power, authority, and influence. This leadership role places hospitals in a position to influence broader policy changes to affect health.

5. Mandate the use of a public health framework

   The final regulations should require nonprofit hospitals to use a community health assessment and planning model (e.g., Planned Approach to Community Health (PATCH), Mobilizing For Action Through Planning and Partnerships (MAPP), Community Health Improvement Process (CHIP), community health development

model) or incorporate components into their CHNA approach. This would aid hospitals in meeting recommendations #2-4, but would also provide some much needed standardization to the processes. Ideally, the final IRS regulations would require a model that includes the following:

- Engage and mobilize the community
- Collect data using multiple sources and methods
- Use quantitative and qualitative data to identify health issues
- Use broad social determinants to identify influences on health issues
- Identify clinical and non-clinical resources
- Identify health disparities
- Organize and broadly share findings
- Set health priorities with community stakeholders
- Develop an action plan to address health priorities
- Use evidence-based and culturally appropriate strategies
- Provide opportunities for continual feedback with and input from community members

Given the history of community benefits, past legislative and regulatory ambiguities, and concerns that not all nonprofit hospitals are providing benefits equivalent to their tax-exempt status, the final regulations should make the regulatory purpose and governmental expectations clear to nonprofit hospitals and to communities in which they reside. Further, the final IRS regulations should include provisions that require use a public health framework that meaningfully engages broad groups of

community members and stakeholders, identifies non-clinical causes and solutions to health issues, and emphasizes population health status improvement. This is a step to begin holding hospitals and other community-based resources accountable for the health of community members in which they serve.

Limitations

This cross-sectional study provides a snapshot at a single point in time and we were not able to directly observe processes. Therefore, we were reliant on reconstructed perspectives represented by the key informants, consultants, and community stakeholders interviewed, which are subject to recall bias. Further, our subjectivity, particularly as it related to our beliefs about nonprofit hospitals' responsibility toward communities, imposed our perspective on the methodology, the research question, and data collection, analysis, and interpretation.

We selected six cases we thought were representative of this population and corroborated our selection with confirmatory cluster analysis. Within each case, we were limited by our ability to reach participants who were involved the assessment and planning processes and report development. Finally, as an unfunded dissertation study, we were limited by time, research team staff, and funding. Phase I and phase II data collection and analyses were time limited, which affected the depth of reporting. Many interviews were conducted by telephone, as travel to most locations was not practicable. This would have enhanced our understanding of the processes as well as internal and external contextual factors. Lastly, we lacked sufficient time and personnel to adequately assess inter-coder reliability.

CHAPTER V

CONCLUSIONS

Nonprofit hospitals in Texas varied widely in their approach to the draft IRS regulations to conduct a community health needs assessment and develop a plan to address identified health priorities. In addition to variations in the overall approach, the quality of the CHNA/implementation strategies reports from the first, three-year cycle also varied. Using a public health framework to evaluate quality, less than one-third scored in the high-quality range. With over 68 percent scoring in the mid- to low-quality range, there are significant improvements that can be made during the second, three-year cycle. The final regulations, once developed and issued by the IRS, should provide clearer guidance and stronger support for using a public health framework to conduct community health needs assessments and develop plans to address health issues. Two factors associated with high report quality were consultant-led CHNA processes and collaboration with local health departments.

Chapter III suggested wide variation in the engagement and participation of community stakeholders and community members during the assessment and planning process. There were differences in the types of stakeholders involved, the depth of stakeholder involvement, and the types of activities in which they participated. Chapter IV suggested broad interpretation and implementation of the draft regulations by nonprofit hospitals in Texas. Primarily, interpretations included expectations for 1) improved documentation and reporting, 2) increased accountability to justify nonprofit

hospitals' tax-exempt status, 3) increased provision of charity care, and 4) shifted emphasis toward population health improvement.

Unless the final regulations provide specific guidance and expectations for these processes and the resulting reports, the quality and approaches will continue to vary widely. The policy implementation will likely prove irregular, at best, and ineffective, at worst. The final regulations should require meaningful engagement of and collaboration with broader stakeholders groups with representation from diverse sectors of the community. Clearer guidance would provide a common framework from which hospitals can conduct assessments, identify and priorities health issues, and develop and implement strategies to address health priorities. Clear communication about the intent of the legislation, regulations and expectations, will standardize interpretation and implementation of the final regulations. Given the concerns that not all nonprofit hospitals provide benefits equivalent to their tax-exempt status and past legislative and regulatory ambiguities, the final regulations should communicate a clear purpose and guidance to nonprofit hospitals and to the communities in which they reside.

Limitations

This study was limited due to its scope and sample size. In phase I, ninety-five CHNA/implementation strategies reports in Texas were reviewed. This accounted for approximately fifty-three percent of the nonprofit hospital population in Texas. While limited to Texas, we think these results are applicable to nonprofit hospitals in other states. A larger sample of hospitals, preferably in multiple states, should be used to replicate the study.

As a retrospective, cross-sectional study, we were not able to directly observe the assessment and planning processes. We were reliant on reconstructed perspectives represented through the key informants, consultants, and community stakeholders, which are subject to recall bias. Our perspective reflected in the methodology, the research questions, data collection, analysis, and interpretation, indicated our belief that a public health framework with extensive involvement of community stakeholders is more effective at improving population health than a medical framework that views health needs and strategies from a strictly clinical perspective.

Six cases were selected, and corroborated with confirmatory cluster analysis, that we thought were representative of this population. Within each case, we were limited by our ability to reach participants who were involved the assessment and planning processes and report development. We had hoped to conduct more interviews with community stakeholders, but the lack of community engagement limited the stakeholders' involved and available to be interviewed.

Implications and Recommendations for Research, Policy, and Practice

Based on these findings, there are clear research, policy, and practice implications. With the widespread availability of CHNA/implementation strategies reports, this first phase of the study should be replicated for nonprofit hospitals throughout the United States. While we think state-to-state differences are minimal, cross-state findings should be compared. Future studies could provide further evidence of characteristics or factors that result in quality reports. The IRS should incorporate these findings into a common public health framework in the final regulations.

Once replicated, the evaluation criteria used to assess the quality of the reports should be revised, tested, standardized and, ultimately, developed into an instrument to evaluate these assessment and planning processes. Such an instrument could supplement the IRS Schedule H reporting form, which currently only has a yes/no checkbox. Further, nonprofit hospitals could use such an instrument to guide and evaluate their own assessment and planning processes.

The ambiguity of past community benefit regulations has contributed to the wide variation in how nonprofit hospitals interpret and provide benefit to the communities they serve. It has also weakened the ability of communities to contest the level of benefit provided by nonprofit hospitals through the legal system. The final regulations should provide clear expectations and define the purpose and intent of the regulations to ensure a more common interpretation and implementation across hospitals. To improve population health status, the final regulations must move beyond hospital accountability and require nonprofit hospitals to begin focusing on community health issues and implementing clinical and non-clinical strategies.

Others have stated the numerous benefits of engaging community stakeholders and community members in community health assessment, organization, and planning processes (Bess, Prilleltensky, Perkins, & Collins, 2009; Eng, Hatch, & Callan, 1985; Granner & Sharpe, 2004; Israel, Schulz, Parker, Becker, 1998; Israel, Schulz, Parker, Becker, Allen, Guzman, 2008; Leung, Yen & Minkler, 2004; Minkler, 2005; Roussos & Fawcett, 2000; Shortell et al., 2002; Spatig, Swedberg, Legrown & Flaherty, 2010; Wallerstein, 1999). Given that “nonprofit hospitals are expected to provide health

benefits to the *local communities* in which they operate," the final regulations should require that hospitals make concerted efforts to include broad community stakeholder groups and community members throughout the assessment and planning processes (Hanson, 2005, p. 405). With the assistance of these broad stakeholder groups, the final IRS regulations should also require the exploration of root causes of health issues, the identification of social, behavioral, environmental, economic, and cultural determinants of health, and strategies to address these broader determinants.

For population health improvements to occur, the final regulations should require hospitals to take a disease prevention and health promotion approach. Involving broad stakeholder groups and looking beyond the clinical perspective of health will aid the identification of root causes of health issues, adoption of clinical *and* non-clinical strategies to address health priorities, and identification of clinical *and* non-clinical community resources. Further, hospitals can use their leadership role to influence broader policy changes to affect health.

Lastly, the final regulations should require nonprofit hospitals to use a community health assessment and planning model. The components incorporated in this model should include engaging and mobilizing the community; collecting data using multiple sources and methods; using quantitative and qualitative data to identify health issues; using broad social determinants to identify influences on health issues; identifying clinical and non-clinical resources; identify health disparities; organizing and broadly share findings; setting health priorities with community stakeholders; developing an action plan to address health priorities; using evidence-based and

culturally appropriate strategies; and providing opportunities for continual feedback with and input from community members.

Reflections

Despite the existence of community benefit departments, hospitals do not appear to have the staff or expertise to conduct community health assessment and health-planning activities as recommended in this dissertation. These departments largely work within the walls of the hospital to serve low-income, uninsured or underinsured patients. Particularly for larger health systems, community benefit activities may be "farmed out" to Federally Qualified Health Centers or other organizations, through small grants, that serve low-income, underserved populations. When community benefit departments are not stand-alone units, "community benefit" staff are usually serving in marketing or public relations-type roles. Given hospital staffs' lack of experience in this area, working with broad community stakeholder groups can provide a broader, non-clinical perspective as well as contribute non-clinical resources. Despite evidence that broader determinants contribute to health, the IRS places little emphasis community building-type activities. Therefore, it is unknown whether they would support and enforce regulations that shift hospitals' focus beyond clinical care. Finally, there seems to be a fear, sometimes unspoken and sometimes expressed, that community health improvement and health promotion activities will drive hospitals out of business. While this fear will affect the implementation of community-based activities, it is outside the scope of the IRS regulations and will likely need to be addressed in other ways.

This study used a mixed methods research design and did not address the paradigmatic issues related to incommensurability. We began with a broad study purpose to understand how nonprofit hospitals were approaching the new IRS requirement. The quantitative data provided a broad overview of how nonprofit hospitals in Texas approached assessment and planning during the first three-year cycle. Further, it informed the research questions, case selection, and interview questions for key informants, consultants, and community stakeholders. The qualitative data provided a much deeper level of understanding and insight into the process at the six case study sites. We believe this embedded, exploratory and confirmatory, mixed methods design strengthened our research study and, despite paradigmatic issues, yielded findings we would not have otherwise, using quantitative or qualitative alone. While we did not address the criticisms of mixed methods research, the continued discourse could likely lead to a new paradigm or address issues of incommensurability in conducting mixed methods research.

REFERENCES

Abbott, A.L. (2011). Community benefits and health reform: Creating new links for public health and not-for-profit hospitals. *J Public Health Management Practice, 17(6),* 524–529.

Anfaran, V.A. & Mertz, N.T. (2006). *Theoretical frameworks in qualitative research.* Thousand Oaks, CA: Sage.

Arnstein, S. (1969). A ladder of citizen participation. *Journal of the American Institute of Planners, 35(4),* 216-224.

Bakken, E. & Kindig, D.A. (2012). Is hospital 'community benefit' charity care? *Wisconsin Medical Journal, 111(5),* 215-219.

Barnett, K. (2012). *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potentia*l. Report of Proceedings from a Public Forum and Interviews of Experts Public Forum convened by the Centers for Disease Control and Prevention, July 11–13, 2011, Atlanta, GA. Retrieved August 22, 2013 from http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf

Baum, F. & McDougall, C. (1995). *The effectiveness consultation guide: Resources for consultation.* Canberra, Australia: Commonwealth Department of Human Services and Health.

Bazzoli, G.J., Clement, J.P., & Hsieh, H.M. (2010). Community benefit activities of private, nonprofit hospitals. *J Health Polit Policy Law, 35(6),* 999-1026.

Berg, J. **(**2009)**.** Population Health and Tax-Exempt Hospitals: Putting the Community back into the "Community Benefit" Standard. Case Research Paper Series in Legal Studies Working Paper 08-22, *Georgia Law Review*, 1-42.

Bergman, M. (2008). *Advances in mixed methods research: Theories and applications.* London: Sage.

Bess, K.D, Prilleltensky, I., Perkins, D.D., & Collins, L.V. (2009). Participatory organizational change in community-based health and human services: From tokenism to political engagement. *Am J Community Psychol, 43*, 134–148.

Burdine, J.N., McLeroy, K.R., Blakely, C., Wendel, M.L., & Felix, M.R. (2010). Community-based participator research and community health development. *Journal of Primary Prevention, 31(1)*, 1-7.

Burdine, J., Felix, M., & Wendel, M. (2007). The basics of community health development. *Texas Public Health Association Journal, 59(1),* 10–11.

Burke, N.J., Joseph, G., Pasick, R.J., & Barker, J.C. (2009). Theorizing social context: Rethinking behavioral theory. *Health Educ Behav, 36(1S),* 55S-70S.

Butterfoss, F.D. & Dunet, D.O. (2005). State plan index: A tool for assessing the quality of state public health plans. *Preventing Chronic Diseases.* Retrieved October 15, 2013 from http://www.cdc.gov/pcd/issues/2005/apr/04_0089.htm

Catholic Health Association [CHA]. (2013). *Assessing and Addressing Community Health Needs.* Retrieved November 3, 2013 from http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4

Centers for Disease Control and Prevention. (1999). Framework for program evaluation in public health. *MMWR,* 48(RR-11). Retrieved October 3, 2013 from http://www.cdc.gov/mmwr/pdf/rr/rr4811.pdf

Centers for Disease Control and Prevention [CDC]. (2011). *Principles of Community Engagement.* CDC/ATSDR Committee on Community Engagement. (2nd ed.) Atlanta, GA: CDC.

Centers for Disease Control and Prevention [CDC]. (2013, March 21). *Social Determinants of Health.* Retrieved September 20, 2013 from http://www.cdc.gov/socialdeterminants/Definitions.html

Centers for Disease Control and Prevention [CDC]. (2013, July 3). *National Public Health Performance Standards (SNPHPS).* Retrieved September 20, 2013 from http://www.cdc.gov/nphpsp/essentialservices.html

Centers for Disease Control and Prevention [CDC]. (2013, October 25). *The Public Health System and the 10 Essential Public Health Services.* Retrieved September 20, 2013 from http://www.cdc.gov/nphpsp/

Charles, C. & DeMario, S. (1993). Lay participation in health care decision making: A conceptual framework. *Journal of Health Politics, Policy, and Law, 18(4*), 884-904.

Chen X, Ender P, Mitchell M. Wells, C. (2003). *Regression with Stata*. Retrieved March 29, 2014 from http://www.ats.ucla.edu/stat/stata/webbooks/reg/default.htm

Committee for the Study of the Future of Public Health. (1988). *The Future of Public Health.* Institute of Medicine, Committee for the Study of the Future of Public

Health, Division of Health Care Services. Washington, DC: National Academy Press.

Congressional Budget Office. (2006*). Nonprofit Hospitals and the Provision of Community Benefits,* Pub. No. 2707. Retrieved December 20, 2013 from http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/76xx/doc7695/12-06-nonprofit.pdf

Congressional Research Services. (2009, November 10). *501(c)(3) Hospitals and the Community Benefit*. Retrieved December 20, 2013 from http://assets.opencrs.com/rpts/RL34605_20091110.pdf

Cousins, J.B., Donohue, J.J., & Bloom, G.A. (1996). Collaborative evaluation in North America: Evaluators' self-reported opinions, practices, and consequences. *American Journal of Evaluation, 17(3),* 207-226.

Cousins, J.B. & Whitmore, E. (1998). Framing participatory evaluation. *New Directions for Evaluation, 1998(80),* 5–23.

Creswell, J.W. & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research.* Thousand Oaks, CA: Sage.

Crossley, M.A. (2012). Tax-Exempt Hospitals, Community Health Needs and Addressing Disparities, U. of Pittsburgh Legal Studies Research Paper No. 2012-18. *Howard Law Journal, Vol. 55(3*), 687-704. Retrieved January 12, 2014 from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2117953

Cullen, A. & Coryn, C.L.S. (2011). Forms and functions of participatory evaluation in international development: A review of the empirical and theoretical literature. *Journal of MultiDisciplinary Evaluation, 7(16),* 32-47.

Doyal, L. (1979). *Political economy of health.* London: Pluto Press.

Dunet, D.O., Butterfoss, F.D., Hamre, R., & Kuester, S. (2005). Using the State Plan Index to evaluate the quality of state plans to prevent obesity and other chronic diseases. *Preventing Chronic Disease.* Retrieved October 15, 2013 http://www.cdc.gov/pcd/issues/2005

Dwyer, J. (1989). *The politics of participation*. *Community Health Studies, 13*(1), 59-65.

Eng, E., Hatch, J. & Callan, A. (1985). Institutionalizing social support through the church and into the community. *Health Educ Behav, 12(1),* 81-92.

Felix, M.R., Burdine, J.N., Wendel, M.L., & Alaniz, A. (2010). Community health development: A strategy for reinventing America's health care system one community at a time. *Journal of Primary Prevention, 31(1-2),* 9-19.

Freudenberg, N., Eng, E., Flay, B, Parcel, G., Rogers, T., & Wallerstein, N. (1994). Strengthening individual and community capacity to prevent disease and promote health: In search of relevant theories and principles. *Health Education & Behavior, 22(3),* 290-306.

Glaser, B. & Strauss, A.L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine Publishing Company.

Goodman, R.M., Speers M.A., McLeroy, K., Fawcett, S., Kegler, M., Parker, E.,…Wallerstein, N. (1998). Identifying and defining the dimensions of

community capacity to provide a basis for measurement. *Health Education and Behavior, 25(3),* 258-278.

Government Accountability Office [GAO]. (2005). *Nonprofit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits.* (GAO Publication No. GAO-05-743T). Washington, D.C.: U.S. Government Printing Office. Retrieved February 17, 2014 from http://www.gao.gov/new.items/d05743t.pdf

Government Accountability Office [GAO]. (2008). *Nonprofit hospitals: Variations in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements.* (GAO Publication No. GAO-08-880). Washington, D.C.: U.S. Government Printing Office. Retrieved February 17, 2014 from http://www.gao.gov/new.items/d08880.pdf

Granner, M.L. & Sharpe, P.A. (2004). Evaluating community coalition characteristics and functioning: A summary of measurement tools. *Health Education Research, 19*(*5*), 514-532.

Greene, J.C. (2006). Toward a methodology of mixed methods social inquiry. *Research in the Schools, 13(1),* 93-98.

Greene, J.C., Caracelli, V.J., & Graham, W.F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11(3),* 255-274.

Groves, R M., Fowler, F. J., Couper, M.P., Lepkowski, J.M., & Singer E. (2010). *Survey methodology* (2 ed). Hoboken, New Jersey: John Wiley & Sons Inc.

Guba, E.G. (1990). *The paradigm dialog*. Thousand Oaks, CA: Sage Publications.

Guba, E.G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage Publications.

Guba, E.G., & Lincoln, Y. S. (Eds.). (1994). *Handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Guba, E.G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. N. Denzin & Lincoln, Y. S (Eds.). *The SAGE Handbook of Qualitative Research.* Thousand Oaks, CA: Sage Publications.

Hancock, T. & Minkler, M. (1999). Community Health Assessment or Healthy Community Assessment. In M. Minkler (Ed.), *Community Organizing and Community Building for Health* (139-156*).* New Brunswick, NJ: Rutgers University Press.

Hacker, K. & Walker, D.K. (2013). Achieving Population Health in Accountable Care Organizations. *American Journal of Public Health, 103(7),* 1163-1167.

Hanson, J. (2005). Are we getting our money's worth? Charity care community benefits, and tax exemption at nonprofit hospitals. *Loyola Consumer Law Review, 17*(*4),* 395-418.

Hawe, P., Shiell, A., & Riley, T. (2009). Theorising Interventions as Events in Systems. *American Journal of Community Psychology, 43(3-4),* 267-76.

Helvin, L.K. (2013). Caring for the Uninsured: Are Not-for-Profit Hospitals Doing Their

Share? *Yale Journal of Health Policy, Law, and Ethics, 8(2),* 421-470.

Hunter, D.J. & Killoran, A. (2004). *Tackling health inequalities: Turning policy into practice? National Health Service Health Development Agency*. London: Health Development Agency. Retrieved March 14, 2014 from http://www.who.int/rpc/meetings/en/Hunter_Killoran_Report.pdf

Institute of Medicine [IOM]. (1997). *Improving Health in the Community: A Role for Performance Monitoring.* Washington, DC: National Academy Press.

Internal Revenue Service [IRS]. (1956). Rev. Rul. 56-185, 1956-1 C.B. 202. Retrieved March 20, 2014 from http://www.irs.gov/pub/irs-tege/rr56-185.pdf

Internal Revenue Service [IRS]. (1969). Rev. Rul. 69-545, 1969-2 C.B. 117. Retrieved March 20, 2014 from http://www.irs.gov/pub/irs-tege/rr69-545.pdf

Internal Revenue Service. (2007, June 14). *Draft Form 990 Redesign Project – Schedule H.* Retrieved March 20, 2014 from http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf

Internal Revenue Service [IRS]. (2013, April 5). *Community Health Needs Assessments for Charitable Hospitals*; Action: Notice of proposed rulemaking Federal Register, 78(66). Retrieved October 15, 2013 from.http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/html/2013-07959.htm.

Internal Revenue Service [IRS]. (2014, March 4). New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act. Retrieved May 1, 2014 from http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act

Israel, B.A., Schulz, A.J., Parker, E.A., Becker, A.B. (1998). Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health. *Annual Review of Public Health, (19),* 173-202.

Israel, B.A., Schulz, A.J., Parker, E.A., Becker, A.B., Allen, A.J., & Guzman, J.R. (2008). Critical issues in developing and following CBPR principles. In M. Minkler & N. Wallerstein. (Eds.) *Community-based participatory research: From process to outcomes.* San Francisco: Jossey-Bass.

Johnson, R.B. & Onwuegbuzie, A.J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33(7),* 14-26.

Johnson, R.B., Onwuegbuzie, A.J., & Turner, L.A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(*2),* 112-133.

Joint Committee on Taxation. (2006, September 12). *Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals* (JCX-40-06), Retrieved March 27, 2014 from https://www.jct.gov/publications.html?func=startdown&id=1481

Kettner, P.M., Moroney, R.M., & Martin, L.L. (1999). *Designing and managing programs: An effectiveness-based approach,* 2nd edition. Thousand Oaks, CA: Sage Publications.

Kretzman, J.P. & McKnight, J.L. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets.* Chicago, IL: ACTA Publications.

Leischow, S.J., Best, A., Trochim, W.M., Clark, P.I., Gallagher, R.S., Marcus, S.E., & Matthews, E. (2008). Systems Thinking to Improve the Public's Health. *Am J Prev Med*, *35*(*2S)*, 196–S203.

Leung, M. W., Yen, I. H., & Minkler, M. (2004). Community based participatory research: A promising approach for increasing epidemiology's relevance in the 21st century. *International Journal of Epidemiology, 33(3),* 499-506.

Llewellyn-Jones, L. & Harvey, D. (2005). The development of a Health Promotion Community Participation Framework. *Australian Journal of Primary Health. 11*(*2*), 136-146.

Lunder, E. & Liu, E.C. (2008). *Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H*. (Congressional Report No. RL34605). Retrieved April 16, 2014 from http://assets.opencrs.com/rpts/RL34605_20080731.pdf

Magnan, S., Fisher, E., Kindig, D., Isham, G., Wood, D., Eustice, M., Backstrom, C., & Leitz, S. (2012). Achieving accountability for health and health care. *Minnesota Medicine*. Retrieved October 3, 2013 from https://www.icsi.org/_asset/qj7tk6/Commentary---Magnan.pdf

Marti-Costa, S. & Serrano-Garcia, I. (1983). Needs assessment and community development: An ideological perspective. *Prevention in Human Service. 2(4),* 75-88. Evanston, IL: Center for Urban Affairs and Policy Research.

McKinley, J.B. & McKinley, S.M (1986). Medical measures and the decline of mortality (pp. 10-23). In Conrad, P. (eds.), *The Sociology of health and Illness*. New York: St. Martins Press.

McKeown T. (1976). *The role of medicine: Dream, mirage, or nemesis?* London, England: Nuffield Provincial Hospitals Trust.

McLeroy, K.R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective of health promotion programs. *Health Education Quarterly, 15(4),* 351-377.

McLeroy, K.R., Norton, B.L., Kegler, M.C., Burdine, J.N., & Sumaya. C.V. (2003). Community-Based Interventions. *American Journal of Public Health, 93(4),* 529-533.

Merriam, S.B. (2009). *Qualitative research: A guide to design and implementation.* San Francisco: Josey-Bass.

Miles, M.B., Huberman, A.M., & Saldana, J. (2013). *Qualitative data analysis: A methods sourcebook* (3 ed). Thousand Oaks, CA: Sage Publications

Minkler, M. (2005). Community-based research partnerships: Challenges and opportunities. *Journal of Urban Health, 82(2),* ii3-ii12.

Morgan, D.L. (2007). Paradigms lost and pragmatism regained: Methodological implications of combining qualitative and quantitative methods. *Journal of Mixed Methods Research, 1(1),* 48-76.

Myers, S. & Stoto, M.A. (2006). Criteria for Assessing the Usefulness of Community Health Assessments: A Literature Review. Santa Monica, CA: RAND Corporation. Retrieved October 17, 2013 from http://www.rand.org/pubs/technical_reports/TR314

National Association of County & City Health Officials [NACCHO]. (n.d.). *Community Health Assessment & Improvement Processes.* Retrieved October 3, 2013 from http://www.naccho.org/topics/infrastructure/CHAIP/upload/CHA-and-CHIP-Processes-JJE.pdf

National Association of County & City Health Officials [NACCHO]. (2013). *MAPP Basics - Introduction to the MAPP Process.* Retrieved December 18, 2013 from http://www.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm

Nicholson, S., Pauly, M.V., Burns, L.R., Baumritter, A., & Asch, D.A. (2000). Measuring community benefits provided by for-profit and non-profit hospitals. *Health Affairs. 19(6),* 168-177.

Nobles, D.J. & Casolino, L.P. (2013). Can accountable care organizations improve population health? Should they try? *JAMA, 309*(*11),* 119-120.

O'Cathain, A., Murphy, E., & Nicholl, J. (2007). Why, and how, mixed methods research is undertaken in health services research in England: a mixed methods study. *BMC Health Services Research, 7(85),* 1-11.

Parra-Medina, D., Taylor, D., Valois, R.F., Rousseau, M., Vincent, M.L., & Reininger, B.M. (2003). The program plan index: an evaluation tool for assessing the quality of adolescent pregnancy prevention program plans. *Health Promotion Practice,*

4(*4)*, 375-384.

Pennel, C.L., McLeroy, K.R., Burdine, J.N., & Matarrita-Castante, D. (2014). Nonprofit Hospitals' Approach to Community Health Needs Assessment. *American Journal of Public Health.* Manuscript submitted for publication.

Pennel, C.L., McLeroy, K.R., Burdine, J.N., Matarrita-Castante, D., & Wang, J. (2014). A mixed methods approach to understanding community participation in community health needs assessments. Manuscript to be submitted for publication.

Public Health Accreditation Board [PHAB]. (2010). Beta Test Site Visits. Public Health Accreditation Board e-newsletter. Retrieved November 1, 2013 from http://archive.constantcontact.com/fs030/1102084465533/archive/1103695445388.html#LETTER.BLOCK21

Public Health Agency of Canada (2007). Community capacity building tool: A tool for planning, building and reflecting on community based health projects. Retrieved May 26, 2014 from http://www.sparc.bc.ca/community-capacity-building-tool

Rifkin, S. (1996). Lessons from community participation in health programs. *Health Policy and Planning, 1(3),* 240-249.

Rosenbaum, S & Margulies, R. (2011). Tax-exempt hospitals and the patient protection and affordable care act: Implications for public health policy and practice. *Public Health Reports, 126 (2),* 283-286.

Rosenbaum, S. (2013). *Principle to Consider for Implementation of a Community Health Needs Assessment Process.* Retrieved January 25, 2014 from The George

Washington University School of Public Health and Health Services http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf

Rosenberg, C.E. (1987). *The care of strangers: The rise of America's hospital system.* New York: Basic Books, Inc.

Roussos S.T. & Fawcett, S.B. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health, 20,* 369-402.

Schensul, J.J. (2009). Community, culture and sustainability in multilevel dynamic systems intervention science. *Am J Community Psychol, 43,* 241-256.

Schlesinger, M., Mitchell, S., & Gray, B. (2003). Measuring community benefits provided by nonprofit and for-profit HMOs. *Inquiry, 40(2),* 114-132.

Sherlock, M.F. & Gravelle, J.G. (2009, November 17). *An Overview of the Nonprofit and Charitable Sector.* (Congressional Report No. R40919). Washington DC: Library of Congress Congressional Research Service. Retrieved April 15, 2014 from http://www.fas.org/sgp/crs/misc/R40919.pdf

Shortell, S.M., Zukoski, A.P., Alexander, J.A., Bazzoli, G.J., Conrad, D.A., Hasnain-Wynia, R.,….Margolin, F.S. (2002). Evaluating partnerships for community health improvement: Tracking the footprints. *Journal of Health Politics, Policy and Law, 27(1),* 49-91.

Small, M.L. (2011). How to conduct a mixed methods study: Recent trends in a rapidly growing literature. *Annu Rev Sociol, 37,* 57-86.

Spatig, L., Swedberg, A., Legrown, T. & Flaherty, P. (2010). The Process of Power: A Story of Collaboration and Community Change. *Community Development, 41(1),* 3-20.

Squires, D.A. (2012). *Explaining high health care spending in the United States: An international comparison of supply, utilization, prices, and quality*, The Commonwealth Fund. Retrieved February 26, 2013 from http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/May/1595_Squires_explaining_high_hlt_care_spending_intl_brief.pdf

Sridharan, S., Go, S., Zinzow, H., Gray, A., &Gutierrez Barrett, M. (2007). Analysis of strategic plans to assess planning for sustainability of comprehensive community initiatives. *Evaluation and Program Planning, 30(1),* 105-113.

Stake, R.E. (1995). *The art of case study.* Thousand Oaks, CA: Sage Publication.

Steuart, G.W. (1975). The People: Motivation, Education, and Action. *Bull N Y Acad Med, 51(1),* 174–185.

Tashakkori, A.T. & Creswell, J.W. (2007). The new era of mixed methods. *Journal of Mixed Methods Research, 1(1),* 3-7.

Tashakkori, A.T. & Teddlie, C. (2003). *Handbook of mixed methods in social and behavioral research.* Thousand Oaks: Sage Publications, Inc.

Teddlie, C. & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of Mixed Methods Research, 1(1),* 77-100.

Texas Department of State Health Services. (2014, March 19). Full Service Local Health Departments and Districts of Texas. Retrieved January 6, 2014 from http://www.dshs.state.tx.us/regions/lhds.shtm.

TMF Health Quality Institute. (2012, April 10). Delivery System Reform Incentive Payments (DSRIP) Menu. Retrieved February 14, 2014 from http://www.hhsc.state.tx.us/1115-docs/DSRIP-Menu-041012.pdf

Trickett, E.J. (2009). Multilevel community-based culturally situated interventions and community impact: An ecological perspective. *Am J Community Psychol, 43,* 257-266.

Trickett, E.J., Beehler, S., Deutsch, C., Green, L.W., Hawe, P., McLeroy.,…Trimble, J.E. (2011). Advancing science of community-level interventions. *American Journal of Public Health, 101(8*), e1-e10.

Turnock, B. (2001). *Public Health: What It Is and How It Works*. Gaitherburg, MD: Aspen.

University of Kansas Work Group for Community Health and Development. Conducting Concerns Surveys. In: Community Tool Box. Lawrence: KS: University of Kansas; 2013. Retrieved January 2, 2010 from http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-concerns-surveys/main

University of Wisconsin Population Health Institute. (2014). *County Health Rankings 2013*. Retrieved February 19, 2014 from http://www.countyhealthrankings.org/

United States Census, (2014, March 27). State & County QuickFacts. Retrieved December 10, 2013 from http://quickfacts.census.gov/qfd/index.html#

United States Department of Agriculture. 2013, May 10. 2013 Rural-Urban Continuum Codes. Retrieved December 15, 2013 from http://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx#.UziAqK1dUlY

U.S. Department of Health and Human Services. (n.d.). Planned approach to community health: guide for the local coordinator. Atlanta, GA: U.S. Department of Health and Human Services, Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion. Retrieved February 14, 2014 from http://www.lgreen.net/patch.pdf

U.S. Department of Health and Human Services. (2014, May 24). Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Retrieved January 30, 2014 from http://healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

Wallerstein, N. (1999). Power between evaluator and community: research relationships within New Mexico's healthier communities. *Social Science & Medicine, 49(1),* 39-53.

Wimberley, R.C. (2008). Sociology with a Southern face: Why are we sociologists and what are we doing about it in the South? *Social Forces, 86(3),* 881-909.

Wu, H. & Volker, D.L. (2009). The use of theory in qualitative approaches to research: application in end-of-life studies. *Journal of Advanced Nursing, 65(12),* 2719-2732.

Yin, R.K. (1994). *Case study research design and methods* (2 ed.). Thousand Oaks, CA: Sage Publications.

Young, G.J., Chou, C., Alexander, J., Lee, S.D., & Raver, E. (2013). Provision of Community Benefits by Tax-Exempt U.S. Hospitals. *New England Journal of Medicine, 368,* 1519-1527.

APPENDIX A

SUBJECTIVITY STATEMENT

This subjectivity statement was written to address how co-authors' education and background influenced perceptions, biases, and assumption. These, in turn, influenced research interests, choice of methodology, as well as the way in which we related to people and collected, analyzed, and interpreted data. Co-authors' education and professional and academic experience are in public health, community development, evaluation, and qualitative and mixed methods research. More specifically, co-authors bring a collaborative planning perspective in which community engagement and community development activities aid capacity building.

We perceive a divide between medicine and public health, not only in terms of services provided but also general understanding of public health principles. We believe health issues are largely influenced by broader, social, environmental, and systemic factors; thus, solutions to health issues must move beyond the walls of hospitals. Communities are physical localities where health problems occur, but communities and their members are also settings, resources and agents for change (McLeroy, Norton, Kegler, Burdine & Sumaya, 2003). Finally, we believe partnerships and collaboration among hospitals, community-based organizations, and agencies can help improve program and service delivery, build community capacity, address social and environmental influences on health, and, theoretically, result in improved population health. We recognize that our role as the data collection instruments, analyzers, and interpreters is influenced by our background, assumptions, and preconceived notions.

Methods discussed in the “Trustworthiness and Rigor” section were incorporated to help reduce these biases, assumptions, and preconceptions.

APPENDIX B

INTERVIEW QUESTIONS

Interview Questions: Hospital Key Informant Interview Questions

1. Name _____
2. Organization _____
3. Title _____

4. I'm interested in learning more about your hospital's Community Health Needs Assessment process. Could you please tell me about this process [how did this come about]?
    a. Do you have a Community Benefits (or equivalent) department?
    b. Did you use a particular model, approach, or template?
    c. [Whether consultant- or staff-led] Why did you [or another] choose this approach?
    d. Who from the hospital was involved?

5. Who external to hospital was involved? [prompts: representatives of agencies, organizations; community members]
    a. How were they identified?
    b. How were they involved? [prompts: data gathering/sharing; collaborative meetings; aided prioritization; aided strategy selection; will assist with implementation strategies; aided dissemination of the report(s)]
    c. What were your experiences working with partners/community members?

6. Was a committee, council, or taskforce formed for this work?
    a. If so:
        i. Who were the members [by organization and position]?
        ii. Are you still meeting?

7. How were health needs identified? How were they prioritized? [prompts: How was data collected? What data sources were used? Who was involved in prioritizing? Did you use a particular method for prioritization? Were certain factors considered?]

8. How were strategies selected to address health needs? [prompts: Who was involved in strategy selection? Were resources used to identify evidence-based strategies? To what extent were these things you were already doing or planned to do?]

9. Will assessment and implementation strategy data be tracked?
    a. If so, how will it be used?

10. Were other types of resources used?

11. Do you expect the new IRS requirements to be more difficult to meet than the community-wide needs assessment required by the state? If so, how much more difficult? Why?

12. Were there any surprises? Did you learn anything new?

13. Did/will this process change how you do anything?

14. What will you do differently next time (if anything)?

15. Was this/how was this funded? [prompts: funded consultant; any external funding; hospital personnel time]

16. Is there anything else about the process you would like to share with me?

17. Is there anyone else in your hospital or an external partner that you could recommend I talk with?

Interview Questions: Consultant Interview Questions

1. Name _____
2. Organization _____
3. Title _____

4. I'm interested in learning more about [name of hospital]'s Community Health Needs Assessment process. Could you please tell me about this process?
    a. How did you become involved?
    b. Did you use a particular model, approach, or template?
        i. If so:
            1. Why did you use this model/approach?
            2. Did you adapt this model/template for [name of hospital]?

5. Who from the hospital was involved? How?

6. Who external to hospital was involved? [prompts: representatives of agencies, organizations; community members]
    a. How were they identified?
    b. How were they involved? [prompts: data gathering/sharing; collaborative meetings; aided prioritization; aided strategy selection; will assist with implementation strategies; aided dissemination of the report(s)]
    c. What was this experience working with partners/community members like?

7. How were health needs identified and prioritized? [prompts: How was data collected? What data sources were used? Who was involved in prioritizing? Did you use a particular method for prioritization? Were certain factors considered?]

8. How were strategies selected to address health needs? [prompts: Who was involved in strategy selection? Were resources used to identify evidence-based strategies? To what extent were these things you were already doing or planned to do?]

9. Were other types of resources used?

10. Will/how will you be involved moving forward? [prompts: Will you be involved with strategy implementation/evaluation? Was your part done when the assessment report was completed?]

11. How many assessments like this have you done for nonprofit hospitals? Do you do other types of assessments? [prompts: community; FQHC; National Public Health Performance Standards Program (NPHPSP), Public Health Accreditation Board (PHAB), other etc.]

12. How did this assessment differ from others you've done?

13. Do you know if a committee, council, or taskforce formed for this work?

14. Were there any surprises from this particular assessment?

15. Is there anything else about the process you would like to share with me?

16. Is there anyone else you could recommend I talk with?

Interview Questions: Community Stakeholder Interview Questions

1. Name _____
2. Organization _____
3. Title _____

4. How did you become involved in the CHNA?

5. What was your involvement in the process? [prompts: shared existing secondary data; provided data through interview, focus group, or survey completion; attended collaborative meetings; aided prioritization; aided strategy selection; aided dissemination of the report(s)]

6. What were your experiences working with [name of hospital] on the assessment?

7. How do you think you will be involved moving forward?

8. Were there any surprises? Did you learn anything new through this process?

9. Would you want to be involved the next time this assessment is conducted?

    a. Why or why not?
    b. If yes, what would you like to see done differently?

10. Is there anything else about the process and your involvement you would like to share with me?

11. Is there anyone else you could recommend I talk with?

APPENDIX C

SITE DESCRIPTIONS

Site 1 Description

Site Description:

Site 1 was located in a nonmetropolitan, Texas-Mexico border county (RUCC=5) with one of the lowest median incomes in the state. The hospital has 93 beds. It is a stand-alone, non-faith-based hospital. In describing the community, the CEO, 01KI01, said, "We have a large Hispanic population here. It really is all about family and all about community, and it's all about what we can do to help each other. When you start with a community already has that value system, it makes it very easy to start working with the community."

Report quality:

Total Score=18

Site 1 was categorized as a low-scoring report. This hospital is located in a poorer, low-resource area. It was difficult to fully understand the process, since the primary person responsible for the assessment and planning process, who was the community marketing staff-person, has moved to a different city for a job. The CEO, 01KI01, provided information, but I got the impression she was not integrally involved and likely had not reviewed the assessment report for some time, as she did not seem to have deep knowledge of the process.

Site 1 organizational structure and support:

The hospital partnered with a group in Austin, who is there "legal group." This group had a model they used to help with structure and format of the report.

Initially, 01KI01indicated there was a survey and participation from several people in the community (this differed from what was in the report). As the conversation went on, it became clear that it really was the board members who served as representatives of the community, as was reported in the assessment and planning report.

She offered to ask board members if they would be willing to talk with me, but I imagined this was not a priority and I did not expect to hear back, which I did not.

Community participation:

Site 1 did not work with a local health department on the assessment and planning process. There was a field office for the Health Services Region. Attempts to reach the public health nurse in the county who worked for the region (there is no LHD) were not successful.

Community stakeholders, beyond the board members, were not involved either. According to 01KI01, "as far as the community input— [that] message really came from our board members, our district board members, because it's such a diverse population of application of people." However, she indicated attempts to get the community more involved: "I'm in the middle of talking to our chamber, our rotary, about we can become more involved in health issues in our community." Further, that "next time I would want to expand the survey process for people. To make sure we're capturing all the issues in our community."

Interpretation and/or implementation:

Site 1's report was very closely tied to DSRIP projects: "All of these are part of our DSRIP initiative, too. [We] rolled it all into one thing so we're not focused on 50 projects and not doing any of them well."

"Because we're the sole hospital within our area, the thing that I learned is that we really need to become the driver of this." Even though they want and feel like they need to take this on, they don't have the expertise or staff to do it.

She also said, "If we're really using this well, with the initiative toward wellness, I'm gonna work myself out of a job. If you really think about it, the ideal goal is not to be—not to have a hospital."

"We decided that, from a hospital perspective, we were gonna start internally first with this initiative, because we're probably one of the largest employers here in our community. Beginning in January we did *The Biggest Loser* within our hospital. The group that won lost 43 percent their body fat. The hospital is a very competitive organization, and up to the point that we were actually trying to get other people to deliver pizza so that people here who were winning the contest, hoping that it would impact—it was truly a great opportunity for us to do it, but then the decision that was made from the teams are continuing on after this."

Description of the process:

1. Data collection
    a. They "partnered with a group out of Austin, who actually happen to be our legal group. They had a model that we used to help with the executive summary as well as table of contents and how we wanted to put it together."
    b. "I will tell you, as far as the community input…the message really came from our board members, our district board members, because it's such a diverse population of people."
2. Community involvement
    a. See 1b above.

b. "We sit right on the border. We have a large Hispanic population here. It really is all about family and all about community, and it's all about what we can do to help each other. When you start with a community that already has that value system, it makes it very easy to start working with the community."
c. When asked about doing things differently, the CEO indicated that "next time I would want to expand the survey process for people. To make sure we're capturing all the issues in our community."

3. Addressing needs
    a. This hospital's CHNA/IS plan was very closely tied to DSRIP projects: "All of these are part of our DSRIP initiative, too. [We] rolled it all into one thing so we're not focused on 50 projects and not doing any of them well."
    b. "We decided that, from a hospital perspective, we were gonna start internally first with this initiative, because we have, we're probably one of the largest employers here in our community. Beginning in January—well, it was probably at the end of January—we did *The Biggest Loser*."

Site 2 Description

Description:

Site 2 was located in a metropolitan, north Texas county (RUCC 1) with one of the highest median incomes in the state. The hospital has 112 beds and is a health care system member, faith-based hospital. I spoke with the Senior Marketing PR consultant for the healthcare system, known as 02KI01.

Report quality:

Total Score=21

Site 2 was categorized as a low-scoring report. I assumed a large health system in a wealthy, high-resource community would produce a higher quality report. However, the use of other existing assessment reports, such as Regional Healthcare Partnership and National Research Corporation reports, which have a very different purpose than the CHNA reports, led to a low score.

02KI01 indicated, in looking at other assessment reports, once completed, that she thought their healthcare system went above and beyond. It would be interesting to know on what she was judging her evaluation of the reports.

Site 2 organizational structure and support:

Site 2's community benefits unit is located in the Marketing/PR department at the healthcare system. This is different from other healthcare systems. While community benefits responsibilities are typically associated with marketing and public relations at the hospital-level, most healthcare systems have community benefits departments. 02KI01 began by trying to "sell me" on how their approach through the marketing department was the best way to go. There was a clear desire to align it with their marketing plan. It is interesting that she saw this as a positive:

> "Our approach to community benefit is very holistic. We're very, very mission oriented in all of our strategies and all of our strategic marketing initiatives are based on our mission, as are all of the visions in our plan based business. Really, the focus of our marketing department is very mission oriented."
>
> "Generally this, what makes our reporting and gathering of information, and dissemination of information is that marketing structure because we have the communicators in place to disseminate and gather information. [It's] a little bit

> easier than say a social work network. Usually that's where you can find community benefit operating from the social work department. It's generally not a strategic focus when it's in those departments, but it is an identified strategic direction for us."

The CHNA was led by healthcare system-level staff. Other than board members, there were no hospital-level staff or community stakeholders involved in the assessment and planning process.

After the CHNAs were conducted, the findings were presented to the hospital boards. Healthcare system-level key informant: "Because they are the community experts…We presented the needs that were identified in the community and they prioritized them."

The extent of hospital staff contributions came from their annual community benefit plan submitted to the healthcare system marketing department, which is the unit responsible for community benefits. Annual community benefit plan were submitted a year prior to implementation for budgeting purposes. Existing activities from these plans were used in the implementation strategies plans. The healthcare system added initiatives for health issues not addressed, which "was done through their marketing structure."

At the healthcare system level, "we established a community benefit committee of our board," who "blessed" the report. "We went to all of the hospital board meetings, all of the not for profit hospital board meetings, and introduced it to them because they are our ties in the community." Then we took it to the board of trustees. We finally received the blessing of the judiciary board."

There was a system-wide decision made to meet hospital-level needs through the system, even if that particular hospital with the need didn't have the capabilities.

Community participation:

The Site 2 CHNA report stated, *"creating healthy communities requires a high level of mutual understanding and collaboration with community individuals and partner groups."* However, site 2 was one of 17 sites that made no attempt to engage the community stakeholders at any point. The healthcare system, for all hospitals within their system, relied wholly on existing reports and assessments conducted by other groups/committees. There were no original primary data collection processes.

While there is a local health department in the county, they did not work with the health department on the assessment and planning process. The county public health official indicated, "I get requests all the time for interviews and data, but I do not specifically remember being asked by one of the hospitals to provide any information."

Interpretation and/or implementation:

During the interview, the key informant indicated they were one of the first to conduct the assessment, even though their reports were published in 2013.

"We were one of the first systems who came due before the guidelines were defined, the rules, so we frictioned under an ever-changing rule. We're trying to get these done, and every week we would get a little change."

There was clear frustration about the personnel and time commitment the process required, working under changing guidelines, the change to complete a Schedule H for each hospital (although it is my understanding this is only required for certain sections), and to do an assessment at joint venture (for-profit) partner facilities.

"The new mandate involved all of the, if you have the joint venture that's licensed as a hospital. Even though it is a for profit institution—so it's not tax exempt. We still have to provide the needs assessment and report on the progress towards the plan… Instead of reporting on 14 hospitals we all of a sudden were reporting on 25." Because of the inclusion of for-profit joint ventures, there was more upfront education that had to take place with those facilities.

There was also a complaint "that the Affordable Care Act mandated that every need be addressed." This is actually not true; there just needs to be a justification for why certain needs will not be met. This may have been one of the changes made after they completed their assessments.

A difference between state and federal reporting is that the State recognizes Medicare/ Medicaid shortfalls and federal government does not.

Description of the process:

The process took about 6 months.

1. Data collection:
    a. "We felt like there was so much data out there. Why not take advantage of it, and we had such a short time period, research—they were changing rules, we had to make a decision about how we were gonna approach it. We said, 'Well, this data exists, and it's pertinent, and it's all relevant, it's all new.'"
    b. "We used the newest statistics, so I felt like that was an excellent source."
    c. For Joint Venture facilities: "We farmed out. We just got overwhelmed at the end and we farmed out to a consultant, some of the Joint Ventures. She basically did the JV group."

2. Community involvement and prioritization:
    a. We “established a community benefit committee of our board. We started with a roll out to them of how the future network were being accomplished, how we defined our community, and got their blessing.”
    b. “We went to all of the hospital board meetings, all of the not for profit hospital board meetings, and introduced it to them because they are our ties in the community.” The hospital boards prioritized the issues for each hospital.
    c. Then we took it to the board of trustees
    d. We finally received the blessing of the judiciary board.
3. Addressing needs
    a. “We said that if there was an identified need in one of our community hospitals that they did not provide services for it, [the need] would be met somehow through our system. We developed a list of services that were provided, because of that system linkage. [We] said, “Okay. If it’s not met here it’s met at the system need indicated we have a referral system and a transfer system through, all through the hospitals,” it’s being met one way or the other.
    b. Because we already had been providing services in the community. We knew we already had our category set up, so that provides services through community health education through—and which comes in a variety of methods. We did it through health screenings and health fairs through support groups through education and wellness events. We already had that structure set up, so it would, it was not difficult to roll that over.

Site 3 Description

Site Description:

Site 3 was located in a nonmetropolitan, southeastern county (RUCC=6) with a low median income. The hospital has 25 beds. It is a stand-alone, non-faith-based hospital. While the facility is owned by the hospital district, the hospital operations have been under ownership of a healthcare management firm since 1998.

In describing the community, 03KI02 said "They're [site 3 hospital] just engaged with the community. They know what's going on, not just in their hospital, but they know what's going on in the community and what kind of impact certain programs are having. They're very engaged, so that's nice to see."

Report quality:

Total Score=35

This is a medium-low resource area and the report was categorized in the medium-range. The assessment and planning processes were led by consultants. The processes were directed and facilitated by the director of planning for the healthcare management firm.

Site 3 organizational structure and support:

There were periodic phone calls to check-in with the site 3 leadership team, which included the CEO, CNO, and CFO, but hospital team's involvement was minimal during the assessment phase. "I think 03KI02 just did her phone interviews and gathered the information that she needed from them. Then, we had a few calls along the way where they were just updating us on the information they had. "

Prioritization of health issues was done by CEO, CNO, and CFO using a "ballot" created by consultants. Structured Prioritization Matrix on pages 85-86 of CHNA. Considered 1) size and prevalence, 2) effectiveness of interventions, and 3) hospital capacity. See below. 03KI03 said, "We seem to be in sync between the three leaders on this end, doing it separately. We submitted it separately, but we all kinda came up with basically the same topic."

Community participation:

The consultant contacted broader groups of community stakeholders to gain their input on health issues and took that information back to the hospital leadership team. Types of stakeholders included School of Nursing representative for local college; Regional DSHS representative (serves 28 counties, no local health department); former long-term staff of housing authority; nursing representative at local ISD; geriatric counseling

representative; assistant superintendent of ISD; county WIC representative; and a hospital volunteer. The CEO, 03KI03, said "I introduced them [the consultants] by way of letter, as well as phone calls. The actual information that was gathered was from 03KI02"

They did not work with a local health department on the CHNA. When asked about involvement of community members in process, 03KI03 said "Not so much, because it was really senior management from the hospital perspective."

No community stakeholders were identified by the consultants or CEO they would recommend I talk with. I called two community stakeholders who were listed in the report. I did not hear back from the WIC staff-person, but the public health official, Family and Community Health Manager, DSHS, returned my call. She indicated she may have received an email from or spoken with a consultant about local health data, but she was not involved otherwise and she did not see the draft or final reports.

Interpretation and/or implementation:

The consultants for this site clearly interpreted the intent as improved documentation and reporting. The senior consultant, 03KI01, who is not directly involved in the CHNA process, thinks nonprofit hospitals are already doing a lot for communities. She believes this is more about documenting what they are doing: "If this portion of the Affordable Care Act was to ensure that not-for-profit hospitals are taking care of the community, then I really question it because not-for-profit hospitals are taking care of the community. I think that they will probably do a better job of documenting that, maybe of telling their story, which I think is good. I don't think that because we've had to go through this process, the hospitals are going to influence the health of the community any more than they already were doing. That's just my opinion."

She later says, "Now, it would not surprise me in the least bit if the [form] 990 starts asking questions like, 'Have you improved the health of the community by your implementation strategy, and how?'"

There were also clear indications of attempts to align the CHNA report with other initiatives. According to 03KI01, "So many of the hospitals are now doing new projects through the DSRIP that it's like, pretty soon, you just will get too—it'll be crazy. You've got your marketing plan going. You've got this implementation plan. You've got your DSRIP projects. They all really need to come together so the hospital can really focus on what they need to do."

The CEO, 03KI03, said, "We pretty much stuck with the previous plan and just expanded on that. Things could change more going from—rather than glucose testing, we're going to go to A1C testing. Also because we do participate in waiver 1115, we're

also trying to make sure that what we were doing would also benefit for additional projects."

Also, "I think data will be used to help us stay on track with our DSRIP project. It's also tracking to say what's the benefit? What are we getting? What are giving to the community? What are we getting—what are we getting as far as information about future projects that we wanna do?"

Process:

Consultants established a 6-step CHNA process primarily based on the IRS guidance and Form 990 Schedule H. To a lesser degree other hospital resources were used: AHA, CHA, and the Health Care Coalition of Texas.
The 6-step process included:

1. Establish parameters and scope
    a. "This really lays the foundation for the rest of the process. What area are we going to study? Not only does that include what area does the hospital say that they serve, but looking at their patient origin data. When a patient's discharged, what zip code do they live in? That really makes sense to study because maybe they serve a really large area, but really, when it comes down to it, 75 or 80 percent or 90 percent of their patients come from a really concentrated area, and that last ten or 15 percent can be widely dispersed. Those people may have very different needs than the area that they really serve. We look at that. We make a data-based decision to what area we're going to study. Then we begin collecting data around that market area that we've determined to study. "
2. Collect and analyze data
    a. We "look at demographics, the health status of the community. You can gather health data and demographics from lots of different places, but we've just found some places that we go to quite often. With health data, we typically look at whatever state we're working in, so for Texas, the health department, getting information from them. Then there's also other studies."
    b. "Are you familiar with BRFSS studies? We get data from them as well. That also varies widely by state as far as what's available, what timeframes. You have to have a certain population size and response rate in order to get some data back from them."
3. Obtain input from persons with special knowledge
    a. Step 2 "helps us determine who we're going to speak with as far as getting input from in the community. The IRS initially came up with three groups, and then modified that to two groups that we needed to get input from. We work with the hospital to see what relationships they may have with the health department or, depending on the state, what they may call

that. Someone who is at a health department equivalent to be able to give us some information as to what's going on in the community."

b. "Then we talk to other people that may represent minority groups, low-income groups. If it's a particular kind of hospital, maybe a long-term acute care hospital, we might get information that more pertains to a senior citizen type population, as well as the entire population of that community. Since there are specific requirements with who we have to speak with, we make sure that that's covered. The hospitals play a key role in determining who that is, helping us contact."
c. "Knowing that community really plays a part into the success of getting input back from the community members. This can also include doing focus groups, town halls, electronic surveys or paper surveys, those types of things to get information."
d. "We usually stick with one-on-one interviews unless there's a need in the community to do something different…so far, we've found that what we get from the one-on-one interviews, when we do other things, we hear that same information."
e. For site 3, several partners were identified by the hospital leadership team, based on previous working relationships, and interviews were conducted by email or phone.
f. Types of stakeholders included School of Nursing representative for local college; Regional DSHS representative (serves 28 counties, no local health department); former long-term staff of housing authority; nursing representative at local ISD; geriatric counseling representative; assistant superintendent of ISD; county WIC representative; and a hospital volunteer.

4. Document and communicate results
    a. "We look at all of our data, come up with what they think are the biggest health needs."
    b. "Our reports, we make sure that, like we said earlier, we cover all the things that the IRS has asked us to. Information on the interviewees, biography of the hospital, description of the community served. If there's any information gaps, which that definitely depends on what kind of community you're working in."
    c. If you weren't able to get information on this type of group or, in certain states that we've worked in, mortality rates are just not available, or they're very old. It's hard to say what your top ten causes of death are if you don't have mortality information. We do have some rather large information gaps, depending on the marketplace or the state that you're working in. Texas, we've been fairly successful at finding some good pieces of information to use."
5. Prioritize community need
    a. Prioritization "involves us working with the hospital, whatever their team that they've identified to work on the community health needs assessment

would be. We have a process that we've used that's worked very well, so now have our group of needs we've identified."

   b. "We have a ballot that the group would review all of the needs and rank them. That way, they can come up with the needs that they're maybe going to work on more significantly, and those that just may not be as impactful for the community for the hospital to spend time and dollars on. We have them rank the needs in three different areas. Breadth and depth, effectiveness of interventions, and then the hospital's ability to serve."
   c. The prioritization process at site 3 involved the CEO, CNO, and CFO.

6. Develop implementation plan
   a. "This is where we take those needs and talk about what the hospital is doing or plans to do to meet each of those needs."
   b. We take the approach of looking back at the data, helping us form a rationale for why we're gonna work on this particular need, what it is that the hospital has going on to meet that need, and then expand on that. It's very specific to each hospital. While the process, like 95KI01 said, is different, what's gonna go into the implementation plan will be very hospital-specific. There's not a one-size-fits-all there to get that completed. Once that's done, the hospital will then track their progress for the next three years until it's time to do it again."

Site 4 Description

Site Description:

Site 4 was in a metropolitan, southeast Texas county (RUCC=1) with the highest income in the state. The hospital has 235 beds. It is a system member, faith-based hospital.

Report quality:

Total Score=35

This is a very high resource area and the report was categorized in the medium-range. It is part of a large health system, is located in and serves a county that has the highest median income in the state and has a county health department.

Site 4 organizational structure and support:

The assessment process was led by a system-level community benefit staff-person with the assistance of a student intern. The assessment and priority selection processes were clearly done at the health system level. However, the priorities were very broad and applicable to any hospital/community.

The hospital-level key informant, 04KI02, was in the Marketing/Community Relations Department. She did not become involved until the development of the implementation strategies plans/reports. The first time she heard about the requirement was after the assessment portion had been done. She was in a meeting with the health system-level community benefit staffer, who said they would be responsible for the implementation strategies report at the hospital-level.

The implementation strategies report was based on her knowledge of existing programs and she spoke with directors of various departments to find out what was already being done. For example, she'd remembered hearing about a smoking cessation program, so she asked around to find out which department that was facilitated by, so they could add that as a strategy. They only came up with new strategies if there was not already something going on. They did look to organizations outside the hospital they would need to partner with to make certain strategies happen. They have not actually started moving forward on the implementations strategies, partner development, or strategy data tracking, but they were having a meeting about it in the coming weeks.

Community participation:

Site 4 did a good job of gathering input from a wide-range of stakeholders. They began getting input from traditional partners that provide care for underserved populations (e.g., FQHCs). They also worked hard to get high-profile, respected community

stakeholders' input and quotes to give it more credibility. After that, "it was really just more of—'okay, who do we know working here in the industry? Who works specifically with the community? We want their feedback. What is the general data that the state is reporting?' We even interviewed—or got a quote from, City Mayor… on what her views are because, again, you want your report to have some kind of credibility. I mean, anybody can slap some stats in a report and say, 'Hey, yeah, we found this here,' and then 'This report says this, this, and this,' but it really did help add credibility to be able to add actual quote from these health leaders and governmental leaders that say, 'Yeah. We agree. This is a need.'"

They did not work with a local health department on the CHNA. The county public health official indicated, "It has been a while since I was involved with this. I don't remember even 'talking' with anyone with site 4 about the community health needs assessment. Seems like I may have a received a couple e-mails just asking about our TB data for the past year but that was all the involvement I remember having. I did not attend any meetings, etc. and I did not get a copy of the report."

Interpretation and/or implementation:

04KI01 indicated these processes have restructured most of the community benefits department, how staff think, and how it operates. She said, "some people hate the needs assessment. Some people hate the process, and it was definitely a difficult one, but I do see the silver lining. One of the silver linings in it is it, in my opinion, did force us—or my department—to really reevaluate how—what are we funding? Are we actually making a difference in the community, or are we just gonna fix this organization that's providing healthcare, but what kind of healthcare are they providing, and what they're focusing on, is that a need in the community. How can our funding go further to make a bigger impact in the community?"

Further, she said, "I see why the rules and the guidelines have changed. We do need to be more in-depth in how we're looking at the community and addressing the needs of it. I have found that the needs assessment, and the implementation plan are on my mind a lot now….whenever I'm doing certain programs or presenting new programs to the hospital. As I told you, I'm in the process of redoing our grant. Our grant question is always right there in the back of my mind, and I think that is actually driving how we—or at least how I go about doing certain things.

"A question I'm specifically adding [to the grant announcement], that has never been on there before, is a section about—I list the three priorities that we identified in the needs assessment, and then I ask them, of the priorities identified by Hospital 04, please explain how your organization, or this particular project, helped impact one of these needs. It helps the external organization think about it, and I think it just helps us make a better decision. It's like, okay, 'are we funding an organization that really is helping the community?' If you can't answer one—say how at least one of these priorities—your

organization is addressing at least one of these priorities, then it is worthy of us saying, 'Okay, should we be funding them? Is this the best use of our funding, if we're trying to make an impact on the community and help the underserved, are we really helping them if an organization can't even say how they're helping with these main areas.'"

04KI01 also indicated there are a lot of changes they will make the next time. Generally, "I think we'll put a little bit more effort into the presentation of it, in addition to the committee—putting a stronger committee together, and jumping on it a little bit further in advance."

Process:

1. Data collection
    a. "We really just built off of what we'd already been doing. We were already doing a smaller scale version of this. Instead of just collecting secondary data and then just organizing it on the sheet, we went more in-depth, and we did conduct interviews, and we did the face-to-face or the phone interviews. "
    b. Gathering secondary data
        i. We got "general state data, of course, so we could have things to compare it to. The Texas Department of State Health—their information—they were a vital resource for us."
    c. Interviews with partners were conducted through "either email interviews—well, where you send them the questions (they can just fill 'em out as they see fit). Some of the interviews were conducted face-to-face, which the volunteer did the majority of the face-to-face interviews, as well as phone interviews."
2. Community involvement:
    a. "The majority of the responsibility of our charity care efforts does fall on this department [community benefit]. We brought on another person, just so we could have a bigger reach [volunteer]."
    b. "We just really started brainstorming. Okay. Who do we feel is an expert in the community? Here in city everybody knows [key partner at local university]. I think, whether he wants that title or not, he is an expert on our community, and [University A] is right down the street from us. It just felt like a natural fit, as far as who to reach out to."
    c. "We even got a quote from City Mayor on what her views are because, again, you want your report to have some kind of credibility. I mean, anybody can slap some stats in a report and say, 'Hey, yeah, we found this here,' and then 'This report says this, this, and this,' but it really did help add credibility to be able to add actual quote from these health leaders and governmental leaders that say, Yeah. We agree. This is a need.'"

d. The whole initiative was approved and driven by our top leadership. My senior vice president, which is [SVP name], I worked closely with her before we even started the needs assessment, we determined what we needed to do. We recognized that the process needed to change. We had to be a little bit more in-depth with it for that year. With [SVP name] and, of course, her reaching out to her fellow executives within the system, each CEO and VP, at each of our community hospitals, were aware of this initiative and had full support. They, themselves, designated who they thought needed to be the point person for their hospital for the needs assessment. We had VP, CEO, general executive buy-ins."
e. The final report was sent to and approved by Community Benefits Board Committee.
f. All the other various committees for our community hospitals and the board members approved it."
g. Then it had to go through a complete final, final overall approval from the board and our CEO later.

3. Addressing needs
    a. "Each community hospital, on their own, had to do their own implementation plan."
    b. "Usually it's the marketing rep, but we have a marketing, and for some, a community relations representative at each hospital that I coordinate with."
    c. "37KI01 approached us saying that we needed to—gave us our community needs assessment and that we needed to come up with our implementation strategy. That was the first time I'd heard really about the IRS and all that and that we needed to do this report, and you kind of reflect on that report for the next year and make sure you're trying to increase your—work on your health priorities."
    d. "She [37KI01] gave us three health priorities, and then we came up with the goal, the objective, strategy and then how we were possibly gonna collaborate with certain partners."
    e. "I kind of came up with ideas with my director and then went over it with administration to make sure these were legit ideas, was it a thing that we could do, or if we could really have the time to do this this next year."
    f. I "reached out to the various departments to gather certain information about our service areas and just different service lines that we focus on"

Site 5 Description

Site Description:

Site 5 was located in a nonmetropolitan county in the Hill Country (RUCC=4) with a low median income. The hospital has 124 beds. It is a stand-alone, non-faith-based hospital. The community was described as very supportive, caring, and engaged.

Report Quality:

Total Score=56

Site 5 was categorized as a high scoring report. The county might be considered low-resource, as a independent stand-alone hospital, in a low-income county without a local health department – they are supported by a DSHS Region. This was one of the only reports and processes with potential to build community capacity.

Site 5 organizational structure and support:

The assessment and planning processes were led by a consultant using a community health development model. Staff and community stakeholders were very engaged in the process. 60KI01 served in a marketing/public relations capacity, was new to health care, and had no idea how to do an assessment. She wanted it to be a collaborative process, not only with the community but also with the consultants so she could learn. Based on the penalty and the opportunity to learn, she convinced leadership to hire a consultant. She has been very open about the cost of consultant services with other hospitals (and with me): $25,000.

Community participation:

Site 5 had extensive community engagement and participation. 05CI01 said, "*we [consultants] actually go meet with the mayor and the sheriff and the head of the United Way and any other big foundation and sit down with them for about a 30-minute interview and really hone in on what they are hearing in their constituencies and what they believe to be the major health issue*." The consulting firm then did 300 to 400 surveys with community members.

Once all data were collected and analyzed, the consultants presented the findings at a community-wide summit. "*The first part of the summit was primarily hearing all of the information that they [the consultant] learned and sharing the report…The second part was roundtable discussions…to spend the next three hours thoroughly discussing*" the issues. "*The consultants then listed about 20 areas*" based on the discussion and each attendee was given three sticky notes to vote. "*Depending on where the majority of sticky notes were, those were the ones we decided or committed to tackle that first three*

years. With six areas identified, the summit attendees broke into groups and each group identified three goals, three strategies, and "*organizations within the community that would be accountable to helping us stay on track for the next three years to do something about each of these areas. Then there were people and organizations that volunteered to partner with us in helping us make headway over the next three years changing that need*."

They worked with a local health department on the CHNA. A local health official came and spoke at the community-wide summit (this individual has since passed away). Sixteen key community members, employers, and government representatives were interviewed and 50 community leaders and citizens attended the community-wide summit.

According to 05CS01, the hospital staff are engaged: "marketing staff came to church to talk about programs and services; social workers participate in a multi-organization/ agency committee related to underserved." She thought talking with broader stakeholders and including them throughout the process gave the report credibility: "'Hey, we've done this assessment. This is a real issue. It's not just, 'You're just saying that cuz you're the hospital.' 'Look, we have met with business leaders and other people in the community and we've done this assessment. We've looked at this hard data and this is something we need to address.' I think it's a way to bring about more collaboration." She feels like the hospital is doing great work, particularly on access issues.

05CS02 said, "It makes me proud that I've paid off every bill I've ever had at the hospital. I'm a single mom for 18 years. I had to pay $25.00 a month when my daughter had her tonsils out. It makes me proud to know, 'Okay, I've paid that off.' Yeah, it helps me build up parents to say, 'Don't be afraid. Go on and get that help that you need because they're gonna work with you.'"

All stakeholders, involved at any point in the process, were sent the final report.

Interpretation and/or implementation:

05CI01 thinks the regulations are not only about hospital accountability, but also about shifting hospitals' focus toward population health improvement. "Three and a half years ago whenever they [the regulations] came out, I sat down and spent a lot of time thinking about where the IRS is ultimately trying to go with this. That's part of why we came up with the strategy that we did, because I believe what they're trying to say is 'if we are going to tax exempt you hospital then you've got to be able to provide us with the documentation and rationale for what that is.' It's really important because I don't know if you've looked at the data or not…he amount of taxes that all of the community non-profit hospitals would have to pay in the United States if they weren't tax exempt is astronomical."

Process:

The process took about 4 months, which is less than the other sites interviewed (ranged from 6 months to a year). The consultant used a five-stage process:

1. Hospital patient data
    a. "Phase one we actually take in the hospital patient data. We gecode that and analyze it from an A to Z perspective. It is hard data on what is ultimately the process areas would be the—in the community because those are the ones that are winding up in hospitalization."
    b. "Every single community has a slightly different medical profile."
2. Community-based secondary data
    a. "In this phase we are looking at all of the secondary data from county health ranking. We also bring in data from any chemical spills, water quality, air quality issues. We look at the disease data again to see if there is widespread obesity, diabetes, smoking."
    b. "We also look at any recent epidemic outbreak, any food born infections. Those elements."
    c. "We go very deep into what's really impacting the community health status."
3. Research
    a. "One-on-one interviews. We actually go meet with the mayor and the sheriff and the head of the United Way and any other big foundation and sit down with them for about a 30-minute interview and really hone in on what they are hearing in their constituencies and what they believe to be the major health issue."
    b. "We also do a telephone survey either 300 or 400 surveys depending on the size of the community."
    c. Then we do an overlay as an option for hospital for their employees and physicians.
4. Community-wide summit
    a. "We do about an hour and a half presentation. We bring in the State Department of Health director who came to speak at [site 5] as well."
    b. "We try to get everybody in that summit. There's usually 75 to 100 people there on the same page in an hour and a half. Here are the heart numbers. Here is what the data tells us. To come up with their top health issues, they put them on sticky notes. We put them on a big wall and then we take a break."
    c. During that break, our team is actually taking all of those sticky notes. If there's 100 people, there would be 300 sticky notes and we quantify them in about 10 categories. Sometimes there's 12 or 14, but most of the time it's about 8, 9, or 10. Then we quantify them into those categories. We do a quick, numeric assessment of those.

d. After the break “we break the groups into individual tables. Each table takes on one of those topics. All right. Their job is to come up with three goals for that topic area.”
e. Let’s say it’s diabetes, right? They will come up with three goals for that topic area and then what they have to do is also help us come up with three tactics for each of the three goals. Then we ask them to further define who should have responsibility and also come up with specific measurable goals. If you took diabetes and let’s say in our data we’ve figured out there’s 18 percent of the population that’s affected by diabetes or pre diabetes. We want to take that number to 15 percent. Then who has to be involved and how are we gonna go from 18 to 15 percent?”

5. Reporting
    a. We “provide two forms of reports”
        i. IRS community reports—“coffee table-type of book about what’s going on in the community.”
        ii. “We do a second form of reporting that is a strategic planning type of report. It really breaks down everything that a hospital ought to be concerned with in their community that affects the strategy of the hospital. That’s not published, but it is part of our package.”

Site 6 Description

Site Description:

Site 6 was located in a metropolitan, central Texas county (RUCC=1) with a very high median income. The hospital has 101 beds. It is a system member, non-faith-based hospital.

Report Quality:

Total Score=55

Site 6 was categorized as high scoring. It is in a high-income county, is part of a large healthcare system, and has a very strong health district and health department.

Site 5 organizational structure and support:

The assessment and planning processes were led by system-level staff. The system-level lead was also integrally involved in a community-wide health assessment led by the county health department. Site 5 used the health issues identified in the community-wide, collaborative health initiative to prioritize

Hospital-level staff became involved in the process during the development of the implementation strategies plan/report.

Community participation:

Site 6 worked with a local health department on the assessment; however, this involvement did not necessarily carry over into the implementation strategies planning/report development. The public health official and system-level key informant appeared to have a strong relationship and enjoy working with one another. Activities are shared and outcomes are mutually beneficial. However, community involvement depended largely on organizations and resources available in each community—not all hospitals in the healthcare system had a local health department, existing collaborations, or engaged community stakeholders.

On collaboration with the health department: “It’s been very positive working in the collaboration with the public health district. I mean, in each community that we’ve done that, obviously extremely knowledgeable and capable. Because they understand it, it’s—you’re not dealing with a bunch of organizations that wanna do something but don’t really know how or have that population health perspective. Which actually, is new for our healthcare system. That’s been difficult for me and for a lotta my team to be able to say, ‘No, it’s not just about treating them.’”

06CS01 is the public health department staff-person, who led the collaborative assessment process and wellness initiative. She indicated, "the initiative began in 2009 and is made up of 160 organizations, a steering committee, four regional subgroups in the county (rural/urban), and currently 11 working groups." Prioritization of health needs took a collaborative approach as well. Prioritization of health needs occurred through 780 survey responses: "We did a lot of work at the grassroots level in terms of where the information came from. We did a prioritization activity after we had developed the entire Community Health Assessment."

Once existing programs and resources within the hospital were identified, the hospital-level staff person, 06KI03, who serves in a marketing/public relations role, reached out to others. She said, "That's the way we kind of started it, where I identified the resources I had available, and those who were willing—cuz not everybody wants to do this type of stuff—got them out there, identified opportunities out in the community by talking to the local health department. A lot of relationship building with the senior centers and different civic organizations that are out there, and just kind of offering to them what we had."

Interpretation and/or implementation:

Not having finalize regulations has created problems: "It's been a lot of a guessing game. It's been a best effort kind of a thing. Knowing that, yes, they're gonna be looked at. They're gonna be scrutinized, and recommendations will be made. Hopefully, we're not gonna be penalized for anything, and I don't think we are. Just having to trust that we're gonna get through this, and we'll have better direction next time. "

"One of the biggest challenges—one of the things that was most difficult about not having final regulations was really identifying the community served. That was a big question. Is it the health systems community? Is it the hospital-specific community? Is that just from, where is it from where the majority of our patients reside? Is it from the county where the hospital resides? We had to just consider all of these different things, and within the hospital, different departments would identify a community differently. Your Strategy, your Business Development, your Marketing sees your community as much bigger than your Quality or Community Benefits that's really looking at the underserved population, the people who are right here in our back yard. That was a conversation that has, it's been a Pandora's Box, honestly, going into it. Every time we look at that definition of community, it becomes a bigger problem."

The site 6 healthcare system hospitals have recently merged with another large healthcare system, who took a very different approach and whose hospitals performed poorly on the report evaluation. It will be interesting to see if they take a different approach the next assessment cycle.

Process:

The process took about 1 year to complete (twice the original timeline, but ensured they "did it right").

1. Data collection
    a. There was an existing health alliance collaboration, led by the local public health district: "The public health district did have their data collected, and exactly how it was collected, we'd have to go back and look at the assessment there."
    b. "Community input and the interviews that we conducted with key informants obviously played a big role in it. That helped, too, with identifying areas where other work was being done. It was through those conversations where we could hear from, whether it was public health, or if it was other community leadership. To be able to say, "This is what I hear people talking about."
    c. "We took our prioritized needs to the key informant, rather than saying, 'Blank check. What's an issue in this community?' To say, 'This is what we've identified as a priority need, and do you agree?' Going through that list and saying, 'Yes, we see this. No, we don't see this as prevalently as other areas.' That helped to give us a little bit of structure and affirmation in what we'd already identified as issues."
2. Community involvement
    a. For health alliance CHA
        i. The health system worked with the public health district and a county health alliance. There was a collaborative process for conducting CHNA, with all area hospitals and many other orgs/agencies involved. Initiative is made up of 160 organizations, a steering committee, four regional subgroups in the county (rural/urban), and currently 11 working groups.
        ii. Prioritization for the public health district occurred by surveying 780 community members.
    b. For site 6 CHNA
        i. "A short survey that went out. It was ten questions, and it revolved around the key areas we'd already identified. That was to help, rather than necessarily confirm, cuz we really already knew these were issues, but more to help us decide how to implement a change. It was an assessment of readiness to change of the community."
        ii. "We tried to get United Way, Chamber, just to get a very broad expansion of the population. In some areas, we did take—well, we went to the free clinics and the food pantries to reach the

underserved population specifically because, again, that's really the top group we're trying to reach with them, with our plans."

3. Addressing priorities
    a. At the system-level: "I just helped to get them organized. Because I work in health care system location, so I'm not familiar with hospital operations. I have to rely on the local people to say, 'We're doing this, so we can continue doing it.'"
    b. At the hospital-level: "I actually just filled in the template, basically, and wrote the narrative of information about what we had done and about our community. The part that 64KI01 had kind of outlined for us. I worked with our marketing person for our region and various people, employees within our hospital that do different services."
    c. "It was basically matching up the priorities that we had identified with the service lines that we had available here. When you look at something like obesity, for example, we have several weight loss programs that we offer. We have a couple of exercise programs. What I did was kind of reach out the people that ran the respective programs, explain to them that I wanted to get them out to the communities that we server to talk about obesity, and then to give them information about what we had available."
    d. "We're working with extremely limited resources down here. When I grab these people to go out and do lectures or screenings or whatever it is, I'm taking them out of clinic time, out of office, out of their regular job. I have to be very cognizant of that. So, I identified opportunities out in the community by talking to the local health department. A lot of relationship building with the senior centers and different civic organizations that are out there, and just kind of offering to them what we had. That, over a 12-month period, kind of started to grow organically. We got a little bit of traction out there, so we are, I'm happy to say to the point where people are actually reaching out to us to come and do these things for them."

APPENDIX D

SITE MEMOS

Site 1 Memo

93KI01
04/18/14
Phone Interview

- It was very difficult to get to the correct person. The Patient Advocate played a huge role in getting me to the correct person.
- I got the strong sense it was really the former VP of marketing that guided the processes while working with the hospital's legal team in Austin. She has since left the organization and community for another position in a different organizations.
- Initially, the CEO indicated there was a survey and participation from several people in the community (this differed from what was in the report). As the conversation went on, it became clear that it really was the board members who served as representatives of the community, as was reported in the report.
- "I will tell you, as far as the community input, we get a lot—message really came from our board members, our district board members, because it's such a diverse population of application of people."
- It was difficult to discern how involved the community was or was not. I don't think the CEO really knows.
- The CEO did say, when asked about doing things differently, that "next time I would want to expand the survey process for people. To make sure we're capturing all the issues in our community."
- This hospital's CHNA/IS plan was very closely tied to DSRIP projects: "All of these are part of our DSRIP initiative, too. [We] rolled it all into one thing so we're not focused on 50 projects and not doing any of them well."
- They feel like they need to take this on, but they don't have the expertise or staff to do it: "I think I learned that because we're the sole hospital within our area, the thing that I learned is that we really need to become the driver of this."
- Implementation strategies:

Interviewee:	It was interesting, because we decided that, from a hospital perspective, we were gonna start internally first with this initiative, because we have, we're probably one of the largest employers here in our community.
Interviewer:	Okay.
Interviewee:	Beginning in January—well, it was probably at the end of January—we did *The Biggest Loser*.
Interviewer:	Okay.
Interviewee:	Within our hospital. We had, the group that won lost 43 percent their body fat.

Interviewer: Wow!

Interviewee: The hospital is a very competitive organization, and up to the point that we were actually trying to get other people to deliver pizza so that people here who were winning the contest, hoping that it would impact—it was truly a great opportunity for us to do it, but then the decision that was made from the teams are continuing on after this.

Shift toward wellness:

Interviewer: Do you think this process will change how you do things?

Interviewee: I think it actually will. If we're really using this well, with the initiative toward wellness, I'm gonna work myself out of a job. If you really think about it, the ideal goal is not to be—not to have a hospital.

- Offered to ask board members if they would be willing to talk with me, but I imagine this is not a priority and I did not expect to hear back.
- Community Stakeholders:
- There is a field office for the Health Services Region. I called and left a message on 5/7 and will try again.

Site 2 Memo

10KI01
03/09/14
Phone interview

- Community benefits director within the marketing department.
- She started out by talking to me about the difficulties they encountered and "selling me" on how their approach through the marketing department was the best way to go. The guidelines changed while they were working on their CHNA report and, as one of the first hospitals to begin the work, they didn't have others to look at. There was a clear desire to align it with their marketing plan.
- She spent the first 20 minutes talking nonstop without me asking a single question. She was clearly prepared to talk about the CHNA process, but it came across more as justification for the approach they took.
- She indicated, in looking at other assessment reports, once completed, that she thought they went above and beyond.
- Process took about 6 months.
- Site 2 relied heavily on RHP assessments. Will take a regional approach next time.
- There was clear frustration about the personnel and time commitment the process required, working under changing guidelines, the change to complete a Schedule H for each hospital (it is my understanding this is only certain sections), and to do an assessment at joint venture partner facilities.
- "We were one of the first systems who came due before the guidelines were defined, the rules, so we frictioned under an ever-changing rule."
- "The new mandate involved all of the, if your, if you have the joint venture that's licensed as a hospital. Even though it is a for profit institution and not—so it's not tax exempt. We still have to provide the needs assessment and report on the progress towards the plan… Instead of reporting on 14 hospitals we all of a sudden were reporting on 25."
- There was also a complaint "that the Affordable Care Act that mandated that every need be addressed." This is actually not true; there just needs to be a justification for why certain needs will not be met. This may have been one of the changes made after they completed their assessments.
- The extent of community participation was: "we went to all of the hospital board meetings, all of the not for profit hospital board meetings, and introduced it to them because they are our ties in the community. All of those boards are community members…that is the body that we chose to prioritize, so the priorities for our needs that are identified needs. They provided the prioritization for that. "
- There was a system-wide decision made to meet hospital-level needs through the system, even if that particular hospital with the need didn't have the capabilities.

- The difference is in reporting: the State recognizes Medicare/Medicaid shortfalls and federal govt does not.
- Community Stakeholders:
- In an email exchange with a county health official, she did not recall being asked for information, data, or input by this or any other hospitals in the county (the hospitals in their county belong to one of two large health systems).

Site 3 Memo

95KI01 and 95KI02
03/24/14
In-person Interview

- Consultants established a CHNA process primarily based on the IRS guidance and Form 990/Schedule H. To a lesser degree other hospital resources were used: AHA, CHA, and the Health Care Coalition of Texas.
- The 6-step process included:
    1. Establish parameters and scope
    2. Collect and analyze data
    3. Obtain input from persons with special knowledge
    4. Document and communicate results
    5. Prioritize community need
    6. Develop implementation plan
- First interview was with two consultants employed by a health care management firm. They work with hospitals throughout the US. They conducted CHNAs for all hospitals they manage, but they also provided CHNA consulting services to hospitals they don't manage. Site 3 is a hospital they manage.
- Theme: The senior consultant, who is not directly involved in the CHNA process, thinks nonprofit hospitals are already doing a lot for communities. She believes this is more about documenting what they are doing: 95KI01: "Again, we just really believe that the not-for-profit hospitals are doing a good job meeting the community needs, and so a lot of this is documentation."
- Later – 95KI01: "If the—this portion of the Affordable Care Act was to ensure that not-for-profit hospitals are taking care of the community, then I really question it because not-for-profit hospitals are taking care of the community. I think that they will probably do a better job of documenting that, maybe of telling their story, which I think is good. I don't think that because we've had to go through this process, the hospitals are going to influence the health of the community any more than they already were doing. That's just my opinion."
- Prioritization: "With a finite number of dollars, they have to decide where they want to spend their money." Does this mean money is being spent on new strategies?
- Issues: Access to health care, continuity of health care (fragmentation), mental health, transportation
- Alignment of programs, but how similar are they? 95KI01: "So many of the hospitals are now doing new projects through the DSRIP that it's like, pretty soon, you just will get too—it'll be crazy. You've got your marketing plan going. You've got this implementation plan. You've got your DSRIP projects. They all really need to come together so the hospital can really focus on what they need to do."

- Impact on population health: “Now, it would not surprise me in the least bit if the 990 starts asking questions like, ‘Have you improved the health of the community by your implementation strategy, and how?’”
- For hospitals they manage, they will continue to work with them on annual community benefits/implementation strategies reporting. For hospitals they just consulted with for the CHNA, that work is done until next time.
- **On engagement** – 95KI02: “They're just engaged with the community. They know what's going on, not just in their hospital, but they know what's going on in the community and what kind of impact certain programs are having. They're very engaged, so that's nice to see.”
- 95KI02: “The way we ask our questions aren't necessarily from the perspective of the hospital. We don't want to know what is the hospital doing, but what are the needs of the community, not just within the hospital's walls?”

95KI03
03/28/14
Phone Interview

- Phone interview felt somewhat rushed. Her time was very limited to begin with, but I didn’t need as much information from her since I’d already met and talked with the consultants that oversaw the process. She didn’t have a whole lot to add. Community partners were not involved in the process – the management company contacted community partners identified by the CEO, CNO, and CFO and emailed or phoned to get information about health issues.
- On community engagement: “I introduced them by way of letter, as well as phone calls. The actual information that was gathered was from 95KI02”
- Interaction between consultant and senior management team (CEO, CNO, CFO) was periodic phone calls for updates
- Alignment: “We pretty much stuck with the previous plan and just expanded on that. Things could change more going from—rather than glucose testing, we’re going to go to A1C testing. Also because we do participate in waiver 1115, we’re also trying to make sure that what we were doing would also benefit for additional projects.”
- Partner/stakeholder Involvement
    - Involvement included – School of Nursing rep for local college; Region 8 DSHS rep (28 counties); former long-term staff of Housing Authority; Nursing rep at local ISD; Geriatric Counseling rep; Assistant Superintendent of ISD; County WIC rep; hospital volunteer.
    - Identification was based on previous relationships in this case. If hospitals had trouble coming up with “partners,” the consultants gave them a list of examples.
    - Extent of involvement was telephone or email interviews by consultants to answer questions.

    - What were questions asked? How were they framed?
- Prioritization was done by CEO, CNO, and CFO using a "ballot" created by consultants. Structured Prioritization Matrix on pages 85-86 of CHNA. Considered 1) size and prevalence, 2) effectiveness of interventions, and 3) hospital capacity. See below.
- Broader resources (beyond health care) were identified but these organizations were not included in the process.
- Involvement of community members in process: "Not so much because it was really senior management from the hospital perspective. I think 95KI02 just did her phone interviews and gathered the information that she needed from them. Then, we had a few calls along the way where they were just updating us on the information they had. "
- Priority selection: "We seem to be in sync between the three leaders on this end, doing it separately. We submitted it separately, but we all kinda came up with basically the same topic. The CFO probably leans a little heavier on the clinical side, rather than—from his perspective versus clinical."
- How this will change things: "We've actually set aside a department called 'Community Benefit,' so that we can better collect the information as far as the time we're spending, the expense we have, trying to pull it together in a little bit more succinct fashion than what we were doing before."
- How data will be used: "I think it'll be used to help us stay on track with our DSRIP project. It's also tracking to say what's the benefit? What are we getting? What are giving to the community? What are we getting—what are we getting as far as information about future projects that we wanna do?"
- Consultants identified CEO as the other person they would recommend I talk with. The CEO did not have anyone to recommend. So, I called two community stakeholders who were listed in the report. I did not hear back from the WIC staff-person, but the public health official, Family and Community Health Manager, DSHS, returned my call. She indicated she may have spoken with a consultant about local health data, but she was not involved otherwise and she did not see the CHNA/IS report.

Site 4 MEMO

37KI01
03/14/14
Phone interview

- Health system-level key informant – served in a community benefit role
- She seemed very open to talking and telling me what she learned and things she'd do differently.
- Focus on underserved because of departments' focus. Had to remind self that it was about population health.
- The process was very similar for each hospital within the system. The CHNA was conducted at the county-level for the primary service area.
- The process has changed the way she looks at things—perspective on things she's doing – grants.
- Waited too long to start…would start sooner, have a committee, make more user friendly (readable). The first year was largely used as a learning experience.
- Adaptation – Originally planned to do a survey and changed their plan. Decided not to do survey because it wouldn't get the information they wanted…they did community partner interviews this time and plan to do a survey next time and will use interview results from this assessment to develop survey (didn't really know what they were doing last time during development).
    - Used primary and secondary service areas
    - Staff was key – health system and hospital level
    - Largely used this first time as a learning experience
    - Health systems identified broad needs and tailored strategies at the hospital level
    - Next time will probably form a committee and meet more often
    - High profile – involved well-known city officials and experts from academia
- Process took about 6 months
- How this might change the way they do things:
- "I found I'm starting to slowly shift it a little bit, to accommodate what we said we're going to do in the implementation plan."
- Has been more strategic in their grant dissemination – the implementation plan has actually forced us, with the grant, specifically, to get even more detailed in how we report and what data we're collecting, which is good.
- Change in perspective: "I mean some people hate the needs assessment. Some people hate the process, and it was definitely a difficult one, but I do see the silver lining. One of the silver linings in it is it, in my opinion, did force us—or my department—to really reevaluate how—what are we funding? Are we actually making a difference in the community, or are we just gonna fix this organization that's providing healthcare, but what kind of healthcare are they

providing, and what they're focusing on, is that a need in the community. How can our funding go further to make a bigger impact in the community?"

- "What people don't realize is people who are insured—well, they realize it, but we forget that the insured and employed population are obese, as well, and they have diabetes, and they're getting cancer, and they're engaging in health risk behaviors, such as driving under the influence, and they're smoking, and they're—it's not just the economically disadvantaged population."
- "That was the thought that we had to keep reminding ourselves of, like, okay, wait. It's not just about the underserved. What about the community as a whole? It's easy, I think, for my department, specifically, to forget that because the majority of what we do is for the underserved, so getting out of that bubble and going, the community is the community, regardless of where they are economically."

37KI02
04/10/14
Phone Interview

- Hospital-level key informant was from the PR/Marketing/Community Relations Department.
- The first time she heard about the requirement was after the assessment portion had been done. She was in a meeting with the health system-level CB staffer, who said they would be responsible for the implementation strategies report at the hospital-level.
- The CHNA and priority selection was clearly done at the health system level. However, the priorities were very broad. 37KI02 talked with directors of various departments to find out what was already being done. It sounded like much of it was based on her knowledge of programs she'd heard about previously. For example, she'd remembered hearing about a smoking cessation program, so she asked around to find out which department that was facilitated by, so they could add that as a strategy. They only came up with new strategies if there was not already something going on.
- They did look at who outside the hospital they would need to partner with to make strategies happen. They have not actually started moving forward on the implementations strategies, partner development, or strategy data tracking. They were having a meeting about it in the coming weeks.

37CS01
04/01/14
Phone Interview

- Stakeholder recommended by KI – FQHC CEO
- FQHC has previously partnered with site 4. Relationship was not developed over the CHNA – they house their family medicine residency program and receive a grant through system-level community benefits department. The information provided was more of a formality. FQHCs can use data/information from site 4 in their grant proposals to other agencies/orgs.

County Public Health Official:

- Also contacted a local health department director who was listed in the assessment as a participant. She remembers receiving an email to ask for tuberculosis data for the assessment. She did not have any other communication and has not seen the CHNA report. She offered to do a phone interview, but didn't think she had anything to add. Based on this information, I didn't think it was worth taking her time to talk by phone.

Site 5 Memo

60KI01
04/03/14
Phone interview

- This was one of the few CHNAs (really, the only) model for conducting CHA with potential to build community capacity.
- 60KI01 served in a marketing/PR capacity for the hospital. She was very happy to share and proud of their process and product. She provided information by email after the interview that describes where each group is in the process of addressing the issues identified.
- She was new to health care and had no idea how to do the CHNA. She wanted it to be a collaborative process, not only with the community but with the consultants so she could learn. Based on the penalty and the opportunity to learn, she convinced leadership to hire a consultant. She has been very open about the cost of consultant services with other hospitals (and with me): $25,000.
- She thought the consultant was important because they helped people to recognize their own biases. Gathered info from community, then analyzed secondary data, put together, and presented at summit.
- The process, from start to finish, took about 4 months (from time they began talking with the consulting firm to having a finished product). It felt like it would have taken them a lot longer if they had done on their own.

- Can already see a difference it's made in helping partner orgs: YMCA was able to receive a grant using the process and data collected.
- Helped provide opportunity for more interaction between hospital and community members.
- The consulting firm was the biggest resource – cost $25,000 and worth it
- She thought she'd learn to do the assessment herself the next time around, but they did such a good job, she wouldn't hesitate to hire them again.

60CI01
4/10/14
Phone Interview

- It was clear a lot of thought went into the process the consultant developed. He had very clear instructions for what the process would take, based on community health development model (although I don't think he knew that's what it was). It was a community engaged process with community stakeholders involved at each step.
- Community Stakeholders

- One of the community stakeholder referenced by 37KI01 was the local Sheriff. I had an interview scheduled, had received his informed consent, and he sent an email indicating he had to reschedule. I called assistant and left a message and emailed both of them, but I was never able to reach them to reschedule the interview.
- I identified three other community stakeholders referenced in the CHNA report: public health official, a faith community Nurse, and YMCA CEO.
- The public health official who was involved has since passed away.

60CS01
4/22/14
Phone Interview

- She was asked to participate because of her work with underserved populations in the area. She was one of the stakeholders initially interviewed for her perspective on local health issues. She was not able to participate in the summit because she was out of town for work.
- She was in agreement with the issues identified and selected as priorities. She was sent a hard copy of the report. They have been in touch with her about collaborative activities related to chronic diseases and education (e.g., discharge coordination for people with chronic diseases). She is also a resource when they have uninsured patients.
- She feels like the hospital is doing great work on access issues. She thinks prevention and wellness is going to be a challenge for the hospital: "Of course, a hospital, cuz they're acute care, really their focus."
- The hospital staff are engaged: marketing staff came to church to talk about programs and services; social workers participate in a multi-organization/agency committee related to underserved.
- Community participation: "'Hey, we've done this assessment. This is a real issue. It's not just, 'You're just saying that cuz you're the hospital.' Look, we have met with business leaders and other people in the community and we've done this assessment. We've looked at this hard data and this is something we need to address.' I think it's a way to bring about more collaboration."
- What would like to see done differently: "Maybe the only thing—and maybe they did this and I wasn't aware of it, but I would like to see them talk to not only kind of key stakeholders in the community, which I think there's value in that, but I would also like to see maybe doing some surveying of, like a census type, of community members. Maybe doing some surveys of families and community members."

60CS02
4/25/14
Phone Interview

- She was asked to participate in an interview for her perspective on local health issues. She was also not able to participate in the summit because she was out of town for work.
- YMCA was able to get a $10,000 grant (only one of five in Texas) based on the CHNA and data related to obesity in the community.
- "I'm gonna say it makes me proud that I've paid off every bill I've ever had at the hospital.
- I've had to be—I'm a single mom for 18 years. I had to pay $25.00 a month when my daughter had her tonsils out. It makes me proud to know, 'Okay. I've paid that off.' Yeah. It helps me build up parents that say, 'Don't be afraid. Go on and get that help that you need because they're gonna work with you.'"
- Community is very supportive, caring, and engaged. "I've got a refrigerator that's going out over at my preschool center, and I probably had—for our 50th anniversary for our preschool center, and I'm thinking, 'I'm gonna have to try to find $2,500.00 to $3,000.00 for a new refrigerator.' I'm not afraid to call 10 or 15 different people to see if I can raise $3,000.00 to get a new refrigerator for my preschool center when 80 percent of the kids in our preschool center are low-income families that are—we're scholar-shipping. I need this. We gotta get a new refrigerator, and that's not something I have in my budget. I feel like if I put the word out there that I'm gonna—I have no doubt that I'm gonna get some funds to help me. I think that speaks volumes about our community. They really understand the need. People go, 'You need a refrigerator? Oh, just go buy you one at Sears.' No. We have 60 kids in a preschool center. We need the commercial one. *A*dd to that, that one is probably 30 years old. We have babied it for 30 years. I think we're pretty good stewards of donations."

Site 6 Memo

64KI01
03/18/14
In-person

- Health system-level community benefit manager
- Doesn't come from health care industry, so she is learning a lot through this process.
- Frustration in dealing with IRS and not having finalized regs. Community involvement depended largely on organizations and resources available in each community.
- The health care system is more on-board with the population health focus. It is the clinicians that are more resistant.
- Population health focus: "It's been positive this round. It's been very positive working in the collaboration with the public health district. I mean, in each community that we've done that, obviously extremely knowledgeable and capable. Because they understand it, it's—you're not dealing with a bunch of organizations that wanna do something but don't really know how or have that population health perspective. Which actually, is new for Health care system . That's been difficult for me and for a lotta my team to be able to say, "No, it's not just about treating them."
- Change for next time: "The areas where we did not have a collaboration, I would want to start to have one. There were two major community areas that we did not do that, where it was done solely by the hospital. I prefer the collaborative area because I do think there's greater opportunity for impact with that, and I think the product is better when you have the stakeholders involved, multiple stakeholders. I think it would be more well rounded. "
- How community is defined: "One of the biggest challenges, I'm not sure if you're gonna ask this question or not, but one of the things that was most difficult about not having final regulations was really identifying, was around the community served. That was a big question. Is it the health systems community? Is it the hospital-specific community? Is that just from, where is it from where the majority of our patients reside? Is it from the county where the hospital resides? We had to just consider all of these different things, and within the hospital, different departments would identify a community differently. Your Strategy, your Business Development, your Marketing sees your community as much bigger than your Quality or Community Benefits that's really looking at the underserved population, the people who are right here in our back yard. That was a conversation that has, it's been a Pandora's Box, honestly, going into it. Every time we look at that definition of community, it becomes a bigger problem."

- Not having finalize regs: “It’s been a lot of a guessing game. It’s been a best effort kind of a thing. Knowing that, yes, they’re gonna be looked at. They’re gonna be scrutinized, and recommendations will be made. Hopefully, we’re not gonna be penalized for anything, and I don’t think we are. Just having to trust that we’re gonna get through this, and we’ll have better direction next time. ”

64KI02
04/16/14
Phone Interview

- Hospital-level KI (CNO) involved in the implementation strategy portion. She worked with leadership team (dietary services, lab, rehab) to determine existing programs. It was helpful to have data at the zip code level through the CHA. More organized process for tracking community programs. Main change is better documentation.
- Just the whole, overall process of non-profit organization and how we justify that status by basically—I don't know what the word is, but giving a value—yeah, valuating services that we provide for free. That was interesting. The difference was explained to me from our CEO about how a for-profit company has to pay taxes. We’re having a business without paying the taxes, so we need to be able to justify, explain what services we are providing equivalent to what we would’ve been paying in taxes.

  Interviewer: Sure. Do you think this will change how your hospital does anything?

  Interviewee: The only thing that might change is better record keeping of what we are doing.

  Interviewer: I know you said you were involved before. Based on that experience, was there anything that you would do differently next time if you were involved in this again?

  Interviewee: No, I don’t think so. It was the first time I had been involved and had done it. I just understand the process better now. Again, just to make sure we’re capturing the things that we’re doing. That’s the main thing. We do a lot of services. I don’t think we needed to add anything. I just think we need to make sure we’re capturing it all.
- Who involved at hospital level: “Dietary services manager who is—she’s very involved with the diabetes education. Our lab manager is very active with health fairs 06:32 and glucose screening. Then our rehab manager with the program for the senior citizens for the physical fitness class.”
- 64KI01 helped us along with—I met with a person from Site 6 Hospital, and then our marketing person, who covers both Site 6 Hospital and Sister hospital. The four of us met together to just kind of plan how we’re gonna do this. Then specifically for our hospital, basically the whole leadership team, we discussed this so we could brainstorm about what services are we providing to the community that target these priorities. We all participated in that. It wasn’t

really a formal process as much as just—it's a formal gathering of information about what we're already doing.

- Partnerships: Some of that I didn't directly work with them as much as the information was shared with us. 64KI01 was more instrumental in working with them to get that information for us.
- Decision-making: We did select the priorities, but we used the demographic—I don't know what it's called. The County Assessment. The county produced a very comprehensive assessment of demographics, and needs, and statistics across our county and by zip code. That's what we used to target what our priority needs were for our service area.

64KI03
04/23/14
Phone Interview

- Position: Regional Marketing Manager.
- Involved in the implementation strategies plan/report. She has done a lot of community outreach work.
- The implementation strategies plan development: "The two girls that were here in the positions before I came had very little experience, so it's kind of like they sent up to health fairs when we were asked to participate and that was kind of it. There was no strategy or anything built around it. What happened was when I came on board, having had the community health background, I sat down with 64KI01. We went over the community health assessment, figured out what we needed to do, and I kind of started building a program based on that."
- Priority need selection: When I met 64KI01, they had already identified the primary needs that they were going to—now, I do know a little bit from back in, from meeting with the Local health alliance, that the other entities that were involved as far as the county level, everybody just kind of sat and, I think, compared notes and said 'Okay, this—obesity is an across-the-board.'"
- Strategy selection:
    - "It was basically matching up the priorities that we had identified with the service lines that we had available here."
    - "We initially started obviously with what we had, because we're working with extremely limited resources down here. When I grab these people to go out and do lectures or screenings or whatever it is, I'm taking them out of clinic time, out of office, out of their regular job. I have to be very cognizant of that."
    - We "identified opportunities out in the community by talking to the local health department. A lot of relationship building with the senior centers and different civic organizations that are out there, and just kind of offering to them what we had."

64CS01
04/16/14
Phone Interview

- Public Health Official: Collaborative process for conducting CHA, with all area hospitals and many other orgs/agencies involved. Initiative began in 2009 and is made up of 160 organizations, a steering committee, four regional subgroups in the county (rural/urban), and currently 11 working groups.
- It took about 1 year to complete (twice the original timeline, but ensured they "did it right").
- Process: "It was a very, very intense, in-depth, labor-intensive process. To really do it for real. Honestly, it took us about—I think we doubled our timeline to actually get it completed from where we started to where we actually finished. Anyway, it was just real obvious that if we were gonna meet the original timeline, it was not gonna be—it wasn't gonna be very good."
- Prioritization of health needs occurred through 780 survey responses: "We did a lot of work at the grassroots level in terms of where the information came from. We did a prioritization activity after we had developed the entire Community Health Assessment."
- Site 6 partner was largely responsible for funding the HCI dashboard.